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JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES

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JAMES C. JOHNSTON, M.D. (ACTING EDITOR)
GEORGE KNOWLES SWINBURNE, M.D.
BOLESLAW LAPOWSKI, M.D.

ORIGINAL COMMUNICATIONS.

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MORIZ KAPOSI

JOURNAL OF
CUTANEOUS AND GENITO-URINARY
DISEASES.

VOL. XX. JUNE, 1902. No. 6.

Original Communications.

THE USE OF THE CAUTERY ON THE PROSTATE THROUGH A PERINEAL OPENING. NEW METHOD WITH PRESENTATION OF INSTRUMENT AND REPORT OF CASES.*

BY WM. N. WISHARD, A.M., M.D.,
Indianapolis, Indiana.

IN presenting a new method of using the cautery, the writer does so with the belief that more extended experience will justify the opinion which he entertains, that the cautery when used upon the prostate should be used with the operative area under the direct observation of the operator and that preliminary opportunity for digital examination of the prostatic urethra, vesical orifice and bladder should be given, and that after the use of the cautery or any other radical operation upon the prostate, bladder drainage should be secured. Our present means of determining the exact character of the intra-vesical and intra-urethral mechanical obstructions produced by enlarged prostate are somewhat limited so far as they relate to examinations made prior to operating. Changes in the condition of the urine, functional disorders of the bladder and digital examination by the rectum afford very inadequate evidence of the character of the obstruction. The increase in the length and the angle of the prostatic end of the urethra, as shown by measurement on a catheter from the meatus to the point where urine is obtained, and the use of exploring instruments, is of considerable value. The use of the ordinary cystoscope is, in the writer's experience, rather difficult and usu-

*Read at the Annual Meeting of the American Association of Genito-Urinary Surgeons, at Atlantic City, April 29, 1902.

ally unsatisfactory. The real mechanical relation of the prostatic outgrowth to the disturbed urinary function can only be revealed by digital and ocular examination, and even then is often difficult to understand. In the writer's experience, a much better idea of the character of the enlargement has been obtained in using the cystoscope through a perineal opening, than in introducing it by the natural channel. Used by either of these methods, the cystoscope affords little information in regard to growths projecting into the prostatic urethra and its greatest value is in outlining sharp irregularities about the vesical orifice and within the bladder. Some twelve years ago, in operating upon his first case for the removal of an enlarged prostate by a combined perineal and suprapubic operation, the writer found a massive "pear" shaped hypertrophy projecting into the bladder, and also well-marked intra-urethral growths. A V-shaped portion of the intra-vesical growth was removed through the suprapubic wound. From observation of the use of the galvano cautery for removal of nasal hypertrophies, the writer was lead to conclude that benefit might be obtained by direct application of the cautery through a perineal wound. (See "Notes on Surgery of the Prostate," JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, March, 1892.) Direct use of the cautery was made in this and in other cases at that time for the double purpose of removing small obstructing growths within the prostatic urethra and about the vesical orifice, and for the reduction in size of the lateral lobes by direct puncture from within the urethra. The method then employed was the introduction of a small tubular speculum through a perineal wound and the use of reflected light from a head mirror. A varying number of punctures was made, to the depth of one-half to three-quarters of an inch. Definite location of the desired point of insertion of the cautery was obtained by both digital and ocular examination. The tenaculum was inserted through the perineal wound along the index finger and the point of the tenaculum directed into the most sharply presenting obstruction. The small speculum was then slipped over the handle of the tenaculum and passed into the prostatic urethra, when, with a little tension on the tenaculum, the tissue was drawn sharply into view at the farther end of the tube. The cautery was also used without the aid of the tenaculum in cauterizing hypertrophied tissue about the vesical orifice. The writer ventures to refer to the method then employed because it is, so far as he is aware, the first effort made to use the cautery through a perineal wound and upon tissue exposed to the view of the operator. The view was then expressed that while the cautery was more easily manipulated than the knife or scissors in the removal of growths about

the vesical orifice through a perineal opening, still it did not appear to be suited to growths of large size. Because of the imperfect method available, the use of the cautery by the foregoing method was not subsequently relied upon. About two years ago, a case was seen in which a suprapubic opening had been made for drainage during an attack of complete retention. At the time the writer saw the case, the suprapubic opening was still in use and it was impossible to introduce a catheter or any other instrument through the urethra into the bladder. The patient's condition at this time was such as to make a prostatectomy inadvisable, and a perineal section was therefore made under local anæsthesia, in the hope of securing sufficient dilatation of the prostatic urethra to permit the use of the catheter and secure closure of the suprapubic opening previously made. A very large growth was found extending high into the bladder and greatly obstructing the introduction of instruments. A Koch's air dilating cold lamp cystoscope was finally introduced through the perineal wound and through it the long straight cautery was used to advantage in cauterizing the growth. Catheterization was subsequently quite easy. In another case shortly afterwards, the same cystoscope and cautery were introduced through the natural channel and the cautery applied to a limited extent on the posterior margin of the vesical orifice, with the result of considerable improvement in bladder function. A movable cautery could easily be adjusted to a cystoscope of this variety by a modification of the alligator-forceps arrangement hereinafter described in connection with a perineal tube.

About six months ago, the writer devised a special instrument for the application of the cautery through a perineal opening (presented to association). It consists, as you will observe, of a straight tube with an oblique opening at its distal end, somewhat in the form of an old-fashioned rectal speculum of this pattern. The tube is forty-two millimeters in circumference and six and one-half inches in length without the obturator. It has an auxiliary tube carrying a small incandescent lamp of low heating power, which is exposed through a small window near the distal end and on the longer side of the tube. On the short side of the distal end of the tube, and almost directly opposite the lamp, a groove is cut in the side of the tube for the insertion of the cautery. The groove is intended to give greater rigidity to the knife and greater certainty in the direction and length of the incision. The forms of the cautery thus far used are here presented and consist in three modifications of the cautery knives, used for nose and throat and other galvano-cautery purposes. It will be observed that one is of greater length than the others and has an oblique angle

corresponding somewhat to the angle of the Bottini knife. These cauteries have a comparatively limited reach, which is, however, somewhat increased by bending the wire near the cautery end and tilting the tube while the cautery is in use. There, is, as you will observe, a plug containing a diagnostic window for closing the outer end of the tube. On the side of this plug is a small nipple, through which air can be pumped into the bladder. A very good view of the prostatic urethra and vesical orifice can be obtained without air dilatation, but the latter is an advantage when the instrument is carried on into the bladder. By counter-pressure with the finger in the rectum, and by tilting the instrument, a better view is obtained of the area immediately behind and on the sides of the vesical orifice.

In the application of the cautery by this method in the first case, it became apparent that greater length to the cautery knife was necessary, or its use would be limited. In the endeavor to overcome this difficulty and to extend the use of the cautery to intra-vesical obstructions, the principle involved in the construction of the so-called "alligator jawed" forceps was utilized in the more recently devised instrument. By this newer instrument, the cautery knife can be made any length or shape and can be used through the tube, while the bladder is dilated with air and while the operator inspects the procedure. It will be observed that parallel bars carrying the cautery are inserted through and become a part of the plug which contains the diagnostic window. The cautery is introduced straight, and brought into position within the bladder over the growth at an oblique angle by manipulating the forceps-handle arrangement on the outside. The lamp is screwed on the end instead of being carried through the auxiliary tube. The auxiliary tube is made larger and utilized for carrying a lens system similar to that used in the ordinary cystoscope, and which enables the operator to see at a right-angle and to observe the cautery knife as it is brought down over the growth within the bladder. It will thus be seen that, with the bladder dilated with air, the operator can obtain a direct view about the vesical orifice or within the bladder, by looking through the diagnostic window in the air plug, or by looking through the lens system in the auxiliary tube he can see at a right-angle. If preferred, the operator can dispense with the lens system attached to the prostatic tube and depend upon the direct view through the window in the air plug. With either of these tubes, by direct inspection through the diagnostic window, better view is obtained of the inside of the bladder than by any instrument the writer has ever used. The instrument is of great value for diagnostic purposes alone. The snare can be used in the occasional cases of pedunculated

lated middle-lobe growths. In pear-shaped or collar-shaped growths, the growth can be split from above downward in two or three positions and a cautery snare placed around the segments, and they can be snared off if desired.

With the first tube and a similar one slightly smaller, and the special shaped cauteries presented, the writer has operated upon four cases where symptoms of prostatic obstruction had to a greater or less extent covered periods of from two to fifteen years. In all four cases the operation was done under local anæsthesia and was preceded by dilatation of the prostatic urethra and perineal drainage over periods varying from one to eight weks. In none of these cases after prolonged drainage and dilatation was the patient able to empty the bladder by voluntary effort. When the bladder was filled with boracic acid solution and the tube removed and voluntary effort made by the patient to empty the bladder, the smallest quantity of residual fluid was four and one-half ounces. In one case, at the time the cautery was used retention was absolute after eight weeks' drainage, as the patient could pass no fluid whatever by voluntary effort. In all four cases the patients are now dependent upon voluntary urination. One of them has no residual urine upon introducing the catheter after urination. In another, a man aged eighty-two, the writer found upon two recent examinations that at one time there was one drachm of urine left in the bladder and at a subsequent time the catheter obtained three drachms. The other two, the writer is not able to report as to the exact quantity of urine, if any, retained in the bladder after voluntary urination, but information from the physicians in charge of these two patients is to the effect that the patients have no bladder symptoms whatever. All four patients are able to retain their urine from three to five hours in the daytime. The writer has no special theory to present in reference to the influence of the cautery upon the hypertrophied prostate, but it is a matter of interest that in these cases, the cautery was used in a comparatively superficial manner about the vesical orifice and within the bladder. In one of them the smallest and thinnest cautery here shown was used, and in this case there is now no residual urine. In all of them the primary perineal section was made for the relief of an acute retention. In two of them the catheter could not be introduced and in the other two the catheter was introduced but blood clots so filled the eye that its use was abandoned and a perineal opening made. Very naturally the comparatively superficial incision made raises the question as to whether the good result was not due to prolonged drainage. Attention in this connection should be drawn to the fact heretofore stated, that there was residual urine

in all of them, and in one complete retention, after prolonged drainage. If the dilatation and drainage are to be credited with the result, it would seem that better bladder function should have existed after prolonged drainage was used and before the application of the cautery. Dr. Bryson has recently called attention to the great vascularity of the area immediately about the vesical orifice, and to the greater danger of hemorrhage where the prostatic capsule is opened in this locality, than where the entrance is made from below. This is a fact which has impressed itself upon all who have had an extended experience in the various methods of attacking the prostate. It would seem probable, therefore, that the cautery exerts a marked influence upon the blood supply of this vascular area and produces nutritional changes. Certainly the depth of the incision in the four cases reported is not great enough to leave a deep groove like the Bottini knife. The newer instrument here presented has not yet been used, and the four cases reported were operated upon by the first model shown. With the newer instrument here presented, a groove can be burned exactly similar to that made by the Bottini cautery. As will be seen, there are three knives of different length, and the longer is practically the same as the Bottini knife. The length or the depth of the incision can be accurately gauged. By holding the outer end of the tube firmly and turning the gauge screw, the depth of the incision is indicated on the scale.

Chetwood has recently devised an instrument for use through a perineal wound, which appears to be susceptible of easy manipulation and has the merit of simplicity in construction. It is, in a sense, a modified Bottini instrument, but does not provide for air dilatation of the bladder or for direct inspection of the operative area in placing the cautery.

It may be of interest to mention the fact that the primary perineal section and dilatation of the prostatic urethra in the four cases reported was made under local anesthesia. The subsequent use of the cautery, after the bladder had been drained, was also in each case made under local anesthesia. The writer does not regard a perineal opening made under local anesthesia as a procedure involving any special risk or any special difficulty in its execution. He has employed this method exclusively in the past three years, where the purpose has been to obtain bladder drainage alone. He has also used this method of anesthesia in several cases of external urethrotomy, and in three cases has removed small stones from the bladder. Dr. Bransford Lewis has devised a depositor for the introduction of cocaine tablets into the urethra, which the writer has had the pleasure of seeing him use, and which is apparently a great improvement over the use of

solutions of cocaine in cocainizing the urethra. The quantity used is less, and it can be more directly applied and limited to the desired area. Schleich's infiltration method was used in the writer's cases for the perineum. In the four cases herein reported, the finger was passed into the wound and the prostatic urethra dilated as far as the finger would reach, immediately after the opening was made. In one case the vesical orifice could not be reached by the finger, and a pair of lithotomy forceps was passed into the bladder and the handles of the forceps spread, in order to dilate the vesical orifice. More or less pain was experienced in each case when the finger was forcibly passed into the prostatic urethra and when the vesical orifice was dilated. The pain was of brief duration, however, as but a few seconds were required for this procedure, and in but one of the cases did the patient complain that the pain was extreme. As the primary operation only contemplated moderate dilatation and subsequent drainage, the procedure can scarcely be classed as a grave one. The cautery was used after the bladder had been rested and the element of congestion in the bladder and prostate relieved by drainage. In only one of the four cases did the patient complain of decided pain when the cautery was used. While the writer does not regard general anesthesia as necessary for making a primary drainage opening, it undoubtedly should be used in some cases at the time the cautery is applied. Its use will, of course, greatly facilitate the ease and accuracy with which the cautery is manipulated.

In presenting a new method of applying the cautery, the writer does not desire to make a special plea for this or any other method. He is free to admit that his leanings have heretofore been decidedly towards enucleation. His present interest in the use of the cautery has resulted from the many recent favorable reports of the Bottini operation. He ventures the hope that the instrument here presented will prove of diagnostic value, and where it is deemed advisable to use the cautery it will make it possible to do so with the operative area under direct inspection by the introduction of the instrument through a perineal opening.

He is glad to express his obligation to the Electro Surgical Instrument Company for their aid in enabling him to develop the instrument.

Report of Cases.

The following reports from physicians in charge of these cases came to hand since this paper was written.

Case I.—M. W., age eighty-five years. Bladder symptoms prior to operations about two years; urination gradually becoming more dif-

ficult; frequently accompanied by pain. Catheter used prior to operation. Operated Aug. 4, 1901, for relief of acute retention of twenty-four hours' duration. Bladder drained about three weeks and cautery applied through tube. At present has about one ounce of residual urine. Urinates every two or three hours during the day and three times at night. The catheter is not now used at all.

Case II.—A. M. R., age sixty-nine years. Bladder symptoms prior to operation fifteen years, including three attacks accompanied by considerable bleeding. No systematic use of the catheter prior to operation. Operated Aug. 8, 1901, by perineal section. Bladder drained about eight weeks and cautery used through tube. At present urinates about every two hours in the daytime and from one to three times at night. After voluntary urination catheter gets no urine part of the time, and occasionally gets one-half ounce. Does not use catheter at all.

Case III.—J. J., age eighty-two years. Bladder symptoms fifteen years. Catheter first used ten years ago, but has only been used occasionally since then. The patient has very frequent attacks of difficult urination. Operated Nov. 11, 1901, by perineal section, for relief of complete retention. Bladder drained two weeks and cautery used through tube. At present patient urinates once every three or four hours in the daytime and about three times at night. Greatest quantity of residual urine found at present three drachms. Patient urinates voluntarily and with ease, and does not use the catheter.

Case IV.—P. C., age seventy-two years. Bladder symptoms three years prior to operation, necessitating frequent use of catheter for past two years. During the past year ten or twelve attacks of greater or less severity, usually accompanied by bleeding. Operated Jan. 3, 1902, by perineal section, for the relief of complete retention. Drained two weeks and cautery used through tube. Now urinates every two or three hours during the day and two or three times at night. Passes urine now with ease and catheter gets one drachm of residual urine.

EIGHT CASES OF TUMOR OF THE TESTICLE: THE CLINICAL HISTORY, THE PATHOLOGIST'S REPORT, THE END RESULT.

By Charles L. Scudder, M.D.,

Surgeon to Out-patients, Massachusetts General Hospital and Assistant in Clinical and Operative Surgery, Harvard Medical School, Boston, Mass.

THE following eight cases of tumor of the testicle have been studied clinically and pathologically with great care. The cases were operated upon at the Massachusetts General Hospital by different surgeons, and it is through the courtesy of these gentlemen that I have been permitted to make this study. No final conclusions can be drawn from so few cases, but the group is suggestive. Pathological examinations were in every instance made by Dr. W. F. Whitney of Boston. The series of illustrations accompanying these cases illustrate definite types of malignant disease occurring in the testicle.

Case I.—A. M., forty-one years old, M. G. H. Record, Vol. VIII., p. 113, October, 1895.

No tubercular, syphilitic, or traumatic history. The left testis has been swollen for three months. It is somewhat enlarged, slightly irregular, hard, not tender. No glandular enlargement. Orchidectomy.

Dr. W. F. Whitney's report after examination of the organ: A large symmetrical testis. On section is seen a homogeneous, pale, slightly translucent surface marked by opaque whitish areas. Microscopical examination showed a growth of spindle-celled tissue, with here and there areas of star-shaped cells having gelatinous appearing tissue between them. Tubules could be seen lying in the midst of this tissue. *Diagnosis*: *Myxosarcoma.*

Five years after this operation for the removal of the myxosarcoma of the left testis, the man is well and in good health.

Case II.—P. F., fifty-seven years old, M. G. H. Record, Vol. 304, p. 119, August, 1895.

One year and a half ago received an injury to the right testis. Six months after this the testis began to increase in size. It has continued to grow larger up to the present time. At present the right testis is three times its natural size. The surface of the tumor is smooth. It is firm to touch. The cord is not enlarged. No glandular enlargement. Orchidectomy.

Dr. W. F. Whitney's report after examination of the organ: The testis is enlarged. Upon section the surface is translucent and moderately firm. Microscopic examination showed large spindle cells and cells of other shapes. There are also solid masses of round cells. *Diagnosis: Myxosarcoma.*

Five years and six months after this operation the patient is well and strong.

Case III.—C. A. H., fifty-four years old. M. G. H. Record, Vol. 327, p. 253, January, 1898.

Case II. Large cells and intercellular substance are seen. Large round-celled Sarcoma, sometimes classed as Endothelioma.

No tubercular, syphilitic, or traumatic history. The left testis has been swollen without apparent cause for four months. The left testis is much enlarged. Its surface is uniformly smooth. It is firm and there is slight tenderness upon deep pressure. The glands are enlarged in both groins. Orchidectomy.

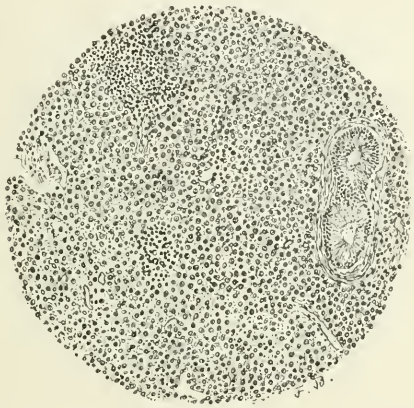
Dr. W. F. Whitney's report after examination of the organ: The testis is enlarged to three times its normal size. The gland structure is replaced by a lobulated new growth of a grayish white surface, which is soft and medullary in consistence and is marked by opaque yellow areas of necrosis. The microscopical examination showed large

round cells separated by a little pale intercellular substance, in the midst of which glandular elements are to be seen. *Diagnois: Round-celled sarcoma.*

Three years after this operation for the removal of the round-cell sarcoma of the testis, the man is well and in excellent health.

Case IV.—S. 9811—1. J. J. C., adult, M. G. H. Record, Vol. XXX., p. 118, November, 1898.

The right testis could always be felt in the inguinal canal, but it never passed through the external abdominal ring; it was undescended.



Case V. The remains of Tubules shown and the growth of inter-tubular areas as seen, composed of small round cells with a little fibrillated intercellular substance. Vascular openings of the nature of sinuses rather than vessels of the wall, areas of minute necrosis, are seen. Small round-celled Sarcoma.

For two years the testis has increased in size gradually growing larger. Three months ago it increased very rapidly in size. It was then tapped and bloody fluid removed. An oval tumor, seven by four inches, exists in the right inguinal region, parallel with the line of the inguinal canal. The skin covering the swelling is edematous and red, and fluctuation is noticed corresponding to the reddened area. There is no impulse to be felt when the man coughs. The cord is apparently thickened. Orchidectomy.

Dr. W. F. Whitney's report after examination of the organ: An oval growth (13 cm. in diameter) with a smooth external fibrous

locking capsule. Upon section of this tumor, the surface appeared lobulated, gray, opaque, soft. In places the surface was necrotic, in other places there were seen soft hemorrhagic cysts. Microscopical examination discovers masses of very large round cells separated by only a little intercellular substance. *Diagnosis: Round-celled sarcoma.* See illustration Case 4.

Two years and a quarter after operation for the removal of this round-celled sarcoma of the testis, the man is well and in good health.

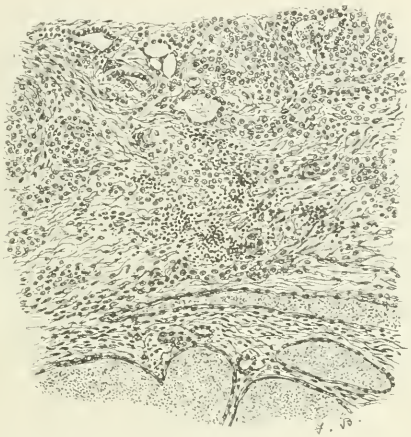
Case VI. Tubules of Testicle seen. Cells proliferating, breaking through and infiltrating in all directions. Adeno Carcinoma.

Case V.—S. 983—3. C. L. O., twenty-eight years old. M. G.H. Record, Vol. XXIV., p. 160, March, 1898.

Double congenital hernia. An undescended left testis. Three months ago an abdominal tumor in the left bladder or hypogastric region slightly to the right side began to appear. A poorly developed man; presented a right iliac and hypogastric tumor. It is smooth in outline; firm, slightly elastic; movable laterally, not longitudinally. It is dull on percussion and slightly tender. The left testis is not in the scrotum. Operation: Tumor removed. Peritoneal fluid was blood. The tumor was adherent posteriorly.

Dr. W. F. Whitney's report after examination of the tumor. An oval tumor (15x10 c.m.) shape of testicle. One portion of the tumor (the body) was covered with a smooth shining membrane on which

were numerous large blood vessels. This portion was of a dark reddish blue color. Another portion of the tumor (corresponding to the epididymis) was an opaque grayish white lobulated medullary growth. Section through the tumor showed the centre to be occupied by an hemorrhagic soft stringy tissue while the periphery was homogeneous pale gray. The mass had a thin elongated tissue attachment, which contained numerous vessels, but there was present nothing which corresponded to a vas deferens. Microscopical examination showed the growth to be composed of large round cells, many with several nuclei,



Case VII. Glandular tissues seen separated by many cells, fibrous and myxomatous tissues seen. Cysto-Adeno-Sarcoma.

having a little granular intercellular substance. No normal testicle tissue was discovered. *Diagnosis: Round-celled sarcoma.* See illustration Case 5.

Seven months after operation he died. The spinal cord was involved in a similar growth from the eleventh dorsal to the first lumbar vertebræ.

Case VI.—S. 93—4. E. H. M., thirty-eight years old, M. G.H. Record, Vol. XXXIV., p. 6, March, 1899.

Two and one-half years ago trauma to the left testis. One year ago a second traumatism to the same testis. Since this last injury the testicle has remained swollen. The left testis is the size of a large

white potato, lobulated, moderately hard, soft in certain parts, not tender to touch. No glandular enlargements. The cord was not enlarged. Orchidectomy.

Dr. W. F. Whitney's report after examination of the tumor: A greatly enlarged testicle, measuring 8 cms. longest axis, somewhat lobulated. The body of the testis was replaced by a soft greenish medullary tissue. Microscopical examination finds that in places tubules can be seen with proliferating epithelium and these can be traced

Case VII. Cartilage tissue seen. Glandular tissue lined with cylindrical Epithelium tissue between Glandular elements, fibrous and in many places associated with growth of striped muscular fibre and Epithelial cell masses which might be regarded as cancerous. Teratoma.

into the new growth, where in places the cells have a slightly tubular arrangement; in other places the cells are in solid masses separated by fibrous septa.—*Diagnosis, Adeno-carcinoma.* See illustration, Case 6.

Two years after the removal of this adeno-carcinoma of the testicle the man is well—in good health.

Case VII.—S. 92-3. J. E. H., adult, M. G. H. Records, Vol. XXXII., p. 144, February, 1891.

Nine months ago, after a blow, testis was painful and enlarged gradually until it was the size of an orange. The surface was smooth.

The swelling was hard; the cord was normal. He lost ten or fifteen pounds in weight. Orchidectomy.

Dr. W. F. Whitney's report: The testicle is enlarged to twice its natural size and is quite smooth upon the surface. On section it was found to be quite largely occupied by a new growth, which was exclusively necrotic in the central parts, but about the periphery was grayish, rather translucent, and with small cysts through it. Microscopical examination showed the remains of tubules surrounded by a large-celled tissue in places having distinct star and spindle-shaped cells. Here and there the tubules were cystic and dilated. *Diagnosis—Cystosarcoma.* See illustration, Case 7.

One year and three months after operation the man died. New growths were found in the spleen and liver, as well as all over the body.

Case VIII.—S. 959-2. J. H. G., fifty-one years old, M. G. H. Records, Vol. 351, p. 140, October, 1899.

No tubercular, syphilitic or traumatic history. One year ago a swelling began of the left testis. This swelling increased gradually and was associated with a dragging feeling in that side of the scrotum. The testicle was the size of a cocoanut, tense, non-translucent. Orchidectomy.

Dr. W. F. Whitney's report was as follows: A tumor, the general shape of the testicle, 18x12 cms. and weighing 1220 grames. The outline is slightly lobulated. On section, it is of an opaque yellow aspect with small translucent areas throughout, especially in the periphery. Microscopical examination showed glandular tissue of a tubular character, fibrous tissue, cartilage and embryonic muscular fibres. In places there were small cysts. *Diagnosis: Teratoma.* See illustration, Case 8.

Six months after the removal of this teratoma of the testicle the patient died.

LICHEN PLANUS AS A VESICULAR AND BULLOUS AFFECTION.*

BY CHARLES WARRENNE ALLEN, M.D.,

Professor of Skin Diseases in the New York Post Graduate Medical School; Consulting Dermatologist to the Randall's Island, and other hospitals; Consulting Genito-Urinary Surgeon to the City Hospital, etc.

GENTLEMEN: It is not my intention to claim, as the title of these brief remarks might cause one to infer, that lichen planus ever exists with moist lesions exclusively or that the latter predominate in any given case.

It has been my privilege to observe during the past year two patients in whom vesicles and bullæ have occurred during the course of their lichen planus, and I desire at this time simply to call attention to a clinical observation so far as I am aware now recorded for the first time that in lichen planus bullæ can at times be developed at will. I desire also to call attention to a plan of treatment in the beginning disease, and especially in the recurrent outbreaks of chronic or subacute cases which seems to prevent the eruption from spreading locally or becoming generalized.

Case I.—Mr. E., æt. 52. Financier. First came to me in January, 1899, with a generalized lichen planus which had begun in the region of the axillæ about three months previously and had gradually extended over the trunk and extremities. There were a few characteristic lesions upon the forehead. As to diagnosis, I will merely state that in the following April, after very marked improvement, a consultation as to therapy was held with Dr. A. R. Robinson, who had no hesitancy even at that time in confirming the diagnosis.

In May, after prolonged arsenical medication, there was a copious eruption of bullæ, some with clear contents and some hemorrhagic, upon the feet.

Four days later, after pain, burning and itching in the region of the right chest-wall, two Zoster plaques appeared; one four inches beneath the nipple, the other opposite the eighth dorsal vertebra. The whole painful area, including the plaques, was painted with benzoated collodion. Fowler's solution, now at daily dose of 33 drops, was gradually decreased.

* Read before the American Dermatological Association at Chicago, June, 1901.

Five days later there were seen scattered over the body numerous clear frank vesicles, and a lesser number of minute vesico-pustules corresponding to those which have been described as aberrant vesicles of Zoster. A month later the body was free from all signs of lichen planus and patient was sent to Aix-les-Bains for a course of baths.

On October 20th patient came to see me, having been home from Europe two weeks. I found that the lesions of lichen which had remained away all summer were beginning to return.

I curetted some of the beginning papules, applied chrysarobin collodion to others, ordered a diet, and gave mineral waters freely. The attack was recovered from and I did not see patient again until the following June (1900). There was at that time, among others, a group of twelve lesions upon the lower back. Upon scraping these flat papules I found that they were quite readily transformed into hemorrhagic vesicles (or minute bullæ) whose walls did not readily rupture. It was not my first experience of this kind and I made a note in my book that this was somewhat characteristic of lichen lesions since other papules did not act in this way. I left these blood blisters to take care of themselves, curetted other lesions and painted still others with the chrysarobin. Within a few days the transformed lesions had disappeared as promptly as those curetted and did not recur. This acute outbreak also ceased and for six months I did not see the patient. Since December last, when there was again a recurrence of lesions in the lumbar region, about the folds of the groin, genitals, thighs and armpits, I have seen the patient almost weekly, and at times more frequently. No medicine has been given, and I may state here that no arsenic was given in the two preceding outbreaks when vesicles containing bloody serum were produced so readily.

I have continued the plan of treatment of curetting the lesions as fast as they form or of transforming them into blood-blisters, since the latter are found to dry up and disappear quite as promptly as the lesions entirely scraped out.

Following this plan there have been no subjective symptoms, no itching, no generalization of eruption and no marked spread. In the infra-axillary region rows of papules have at times formed in the intervals between the visits. Each papule corresponding to a follicular opening, or "goose-flesh" elevation, the direction of the line corresponding to the natural line of implantation of the sweat duct openings for the region involved.

Occasionally, with the aid of a magnifying glass, minute red dots could be made out as a continuation of this line downward, and these could be rendered more apparent by scraping, but once scraped with

the curette even without rupturing the skin they would disappear and no new lesions would develop in the immediate neighborhood. Upon the skin of the lumbar region numerous lesions could at times be raised into tense rounded vesicles with the central shiny thickened epidermis still intact making a striking and peculiar clinical demonstration of *scaly* vesicles. At times also vesicles have arisen spontaneously under strips of adhesive mercurial plaster, which when pricked would pour out a droplet of clear yellowish serum.

Case II.—This relates to a Miss S., æt. 38, who came to my office in November, 1900, with well marked lichen planus. There was a history of a similar eruption having begun on the wrists two years before and disappearing completely. The present eruption had begun during the preceding summer, first about the ankles, after mosquito bites, she says, which caused intense itching and much scratching. Just before coming to me, and while under treatment by internal as well as external measures, there was an outbreak of water-blisters upon the foot soles, which the patient says were filled with a pink liquid. From above the knees to the backs of the feet the confluent plaques make an almost solid mass of infiltration. Upon the chest there are rows of lesions like the beads of a rosary as well as small grouped lesions.

As to the diagnosis in this case, I will state that the eruption soon became generalized, extending from the scalp margin, over the back of the neck, and involving the feet, and in this stage I presented the patient at the New York Dermatological Society and again some months later, when the lesions had almost wholly disappeared. All those present agreed with the diagnosis. On January 12th of this year there was a second outbreak of bullæ upon the feet especially implicating the soles and sides of the feet. No arsenic had been taken since Dec. 22nd (twenty days).

In this case it has been possible to scrape large flat polygonal lesions and transform them into "water-blisters," which would spontaneously disappear. The patient has practiced this herself under my directions and has noted the beneficial results. Many large hypertrophic verrucous or corneous lesions (lichen corneus) I have curetted and removed in this way, as well as the beaded and grouped papules on the chest.

I am not aware that up to the time of my directing attention to curettage as a valuable means of removing the lesions of lichen, by speaking of it at the New York Dermatological Society last year, any published reports upon the method have appeared.

I believe it has a distinct value, not alone in early cases in which the papules are of very soft consistence, but also in the late warty

plaques, whose bases break down much more readily under the sharp spoon than one would be led to believe before a trial.

One of my patients has made the observation in her own person that scratching is at times capable of producing new lesions which "raise up" somewhat like the smaller lesions of urticaria. In piercing one of these fresh lesions a minute quantity of serum can be obtained which is not the case, I believe, as a rule, in urticaria.

Bullæ have long been known to occur in lichen, but their relation to the affection has been too generally ignored and often misinterpreted. Many have looked upon their presence as an accidental complication or due wholly to the use of arsenic. American more than English writers have ignored or denied the possibility of vesicular, bullous, or pustular lesions as occasional features of the disease, and we should be the first to make our text-book descriptions comply more closely with the facts. Dr. Fox, in his article on lichen in Morrow's system, says, "Although the papules in lichen planus never change into vesicles or pustules, I have seen a patch upon the tibial aspect of the leg become the seat of ulceration." At the 289th meeting of the New York Dermatological Society this author showed a case of lichen planus with "pustulation which seemed to be a part of the eruption."

Sequeira* mentions the early occurrence of bullæ before arsenic had been taken.

Pringle† saw a case profusely bullous soon after admission to hospital, and has observed four cases of Zoster in the course of generalized lichen planus apart from arsenical treatment. Kaposi and Leredde have also made the observation that bullæ could occur when arsenical treatment was not a factor.

Further clinical evidence that Zoster may occur independently of arsenical treatment is given by Lusk's case‡ in which marked Zoster was observed during the administration of bichloride of mercury. Engman in the same issue of the *Journal* refers to lesions having the appearance of small flabby bullæ from which the fluid had escaped or become absorbed leaving a shrivelled milky white pellicle. This condition I have likewise noted and have seen actual bullæ with fluid contents still intact in lesions which have developed beneath mercurial plaster applied over a patch of lichen planus. Other lesions often look as though they contained serum, but it is usually only by such irritation as I have described that they become transformed into actual bullous lesions.

In Engman's case the base was found dry on removal of the epi-

* British Journal of Dermatology, December, 1900.
† Loc. Cit.
‡ Journal of Cutaneous and Genito-Urinary Diseases, May, 1901.

dermis, but from my personal observations I can readily believe that fluid had existed in the lesions he describes. Others speak of yellowish or whitish lesions which simulate vesicles or vesico-pustules and yet as Brocq says "when scraped not the slightest vestige of fluid is present."

He says, however, that bullæ may complicate the disease, and a variety of lichen is mentioned in which, especially when the general condition of the patient is not good, pemphigoid bullæ appear here and there disseminated upon preëxisting lesions or even upon the healthy skin.

Now, without entering upon anatomical considerations, I desire to state a few points upon which my belief is based that vesicles and bullæ may be at times an essential part of the process designated as lichen planus and not mere accidental and complicating forms.

While pathologists are not in full accord it is quite clear that lichen planus constantly develops around a sweat coil in the upper layers of the corium. The majority of observers seem to find that the umbilication is due to the middle portion of the papule being held down by a more or less altered duct of a sudoriparous gland or the corneous cone which forms in its upper portion.

A certain proportion of patients have their first eruption in warm weather when the sweat glands are active, and it is with the advent of the heated term that recurrences are often noted. In many patients the parts rich in sweat glands are primarily or notably implicated, viz.: the axillæ, folds of the groins, the genital and lumbar regions, and Crocker has called attention to the fact that the infantile form is seen in those especially who perspire freely. It would appear, therefore, that the outpour of serum producing the vesicle might have a connection with vitiated coil gland secretion. The only confirmation of the clinical facts which I have seen in recent literature is the observation of Whitfield,* who found in three nodules of lichen planus excised a definite vesicle below the epidermis. While the clinical facts here embodied may not aid materially in elucidating any of the unknown features of lichen planus, they should serve to modify text-book descriptions.

It does not seem quite proper to state, as the books do, that the papule persists during its whole course without ever becoming transformed into other lesion of a greater degree of efflorescence, or that they accomplish their whole evolution in all instances under the aspect of papules.

30 East Thirty-third Street.

* British Journal of Dermatology, Dec., 1900.

Society Transactions.

FRENCH SOCIETY OF GENITO-URINARY SURGERY.

FIFTH SESSION.

(*Annales des Mal. d. Org. Génito-Urin.*, 1901, p. 1370.)

(Conclusion.)

Contributions to the Physiology and Pathology of Incision and Extirpation of the Kidney.—Dr. Escat wished to add a word on the value of the reno-renal reflex as a surgical indication. He recalled 2 cases, seen by him 3 years before, of unilateral pyonephrosis consecutive to ureteral fistula of surgical origin, which presented marked symptoms of uremia.

In one case extirpation of the affected kidney as advised by him was done by the surgeon consulting him, and lead to cessation of the uremia. The second, an exactly similar case, refused operation and died with symptoms typical of uremia. Twenty days before death he was called in, there was complete anuria, incessant vomiting; death was imminent. He was able to open up the ureteral fistula with a stylet; the flow of urine was re-established, the vomiting ceased and the patient survived 20 days.

He is convinced that in unilateral pyelonephritis the patients die more frequently from uremia than from the infection.

Dr. Loumeau recalled the case of a patient with advanced interstitial nephritis who became progressively anemic from a profuse unilateral hematuria which had resisted all medication, and had reached such a degree of exhaustion and feebleness that she was almost *in extremis* when he operated for lumbar nephrectomy. The hemorrhage was checked and the patient seemed to be rallying, but died on the twentieth day after operation. He thinks perhaps the remaining kidney was insufficient and that had a nephrotomy been done with a view to checking the hemorrhage and preserving an organ which had not completely lost its function a more favorable result might have ensued.

Nephrotomy in Renal Congestion.—Dr. H. Reynès.—The question of surgical intervention for medical forms of nephritis is in its veriest infancy and does not admit of any conclusion; the case is different with inflammatory nephrites, acute or chronic, which are non-suppurating, painful or hematuric; here nephrotomy gives good results, suppressing the congestion, pain and hemorrhage. He reports a case of a young woman who after a cystitis had an attack of hematuria, unilateral nephralgia and painful swelling of the left kidney, fever, anorexia, and emaciation. A lumbar nephrotomy was done. There was complete absence of pus, previously noted by cystoscopic examination, there was present a congestive nephritis only. The result was excellent; the fever, swelling, pain and hemorrhage subsided and patient progressively gained in health.

Dr. Loumeau reported a case similar to the preceding. A woman, 46, with

cystitis due to calculus, a thick fetid purulent urine, an enormous and painful right kidney. The calculus was removed by the vaginal route and a vesico-vaginal fistula left for free dramage of the bladder and secondarily of the right kidney, which was believed to have been infected by an ascending route. After a while the fistula was closed on demand of the patient. The kidney had continued large and painful, the urine always remained purulent. A lumbar nephrotomy was done, supposing that he had an enormous pyonephrosis to deal with, but the kidney showed only a considerable amount of congestion but no trace of suppuration. He sutured the kidney immediately with catgut and the wound healed by primary union and the patient made a good recovery from an operation which he had believed at first only revealed an error in diagnosis; but it also led to a progressive diminution of the size and the pain.

DR. POUSSON related a case seen by him in consultation 4 or 5 years previously, which appeared to have a large suppurating kidney. Operation showed only an enormous congestion of the kidney with a small abscess in the superior portion. The patient recovered and is still in excellent health.

Facts of this nature prove that our field of study has been extended, thanks to surgery of the kidney. We had already our cases of kidney which were clearly surgical, we are adding to these certain cases of kidney formerly called medical. Albuminuria, the mechanism of which we are entirely ignorant, is far from being a contraindication to intervention. Indeed, the contrary is true, and he thinks that which was stated by Verneuil 20 years ago, apropos of awakening of diatheses by operative traumatism was an error of interpretation.

Case of Paranephritic Cyst.—DR. VIGNARD reported such a case. A man 36 years old without antecedent urinary symptoms. The tumor developed rapidly and filled one-third of the abdomen. It was found attached to the anterior surface and convex border of the kidney, which had a normal appearance. The wall of the cyst was extremely thin and of a uniform smoothness. It contained a serous fluid which was analyzed by Professor Andouard and found to contain 1.67 grammes to the litre of urea.

Owing to the exhaustion of the patient intervention was limited to incision and drainage. Rapid recovery followed in 20 days without fistula, and there has been no recurrence in a year and a half.

The author claims that there is a scarcity of reports of similar cases.

Voluminous Hematonephrosis. Cryoscopy.—DR. F. LEGUEU reported a case in which by a transperitoneal nephrectomy he had removed a large cystic tumor of the left kidney.

The patient was a man 38 years old, who was sent to his service in the *Hôtel Dieu* with a tumor in the flank, with a diagnosis of abscess of the spleen. For several weeks the patient had presented signs of pleurisy, which had brought him to the hospital. Puncture in the seventh intercostal space was made and a cloudy, sanguinolent fluid withdrawn.

He found on examination an immense tumor occupying the entire left side of the abdominal cavity, tense, extending high up under the ribs and into the lumbar region. The insidiousness of the tumor, the nature of the fluid obtained made him believe that it had to do with a cyst of the spleen and he made an abdominal median incision.

He came upon a retro-peritoneal tumor from which he withdrew two and a half litres of a brown colored, sanious fluid. He was able to make complete re

moval of the pocket without applying a single ligature and without finding a pedicle.

The patient recovered.

A histological examination revealed in the thin pocket flattened tubules and altered glomeruli though recognizable, with minute interstitial hemorrhages into the wall.

It was then a hematonephrosis of the left kidney, probably very old, of which he had not recognized the nature, even at the time of operation because of the atrophy of the renal vessels and absence of the ureter, probably obliterated, which had completely escaped him

With Hallion he had made a cryoscopic examination of the fluid with the following result: The freezing point called was 0.55, consequently about equal to that of blood serum, and lower than that of the urine which varies between 1.30 and 2. Therefore the renal epithelium much altered acts like an inert membrane, at least admitting that the tension primitively elevated, had diminished by resorption.

He believes that from a study of the point of congelation of the fluid of a hydronephrosis we can draw a conclusion, prognostic or diagnostic. Prognostic. Where the Δ of the fluid is above 1 we may conclude that the renal epithelium is but little changed.

Diagnostic: Because in the presence of an abdominal tumor of which the fluid withdrawn by puncture and examined presents a higher than .55 the chances are in favor of a hydronephrosis, because other pathological fluids examined thus far have only varied slightly from the point of view of their osmotic tension, from that of blood serum.

Tuberculosis and Hydronephrosis.—Dr. F. Legueu reported a case in which he had performed a nephrectomy for a hydronephrosis due to a narrow stricture of the upper end of the ureter which was attended by a movable condition of the kidney, which after removal was also found to be studded with miliary abscesses, together with 3 large tuberculous cavities, characteristic bacilli and giant cells were found present. He claims that the association of tuberculous lesions and a stricture of the ureter is very rare.

Dr. Albarran recalled a case he had recently presented before the Society of Surgery, of a tuberculous kidney associated with a hydronephrosis. In this case small calculi obstructed the lumen of the ureter. Cases of this nature are sufficiently rare. This case was not a tuberculous hydronephrosis but a simple coexistence of a hydronephrosis with a tuberculous kidney.

Case of Ulcerative Lesion of the Urethra.—Dr. Riedinger.—The report was that of a patient who, affected with stricture of the urethra, presented the symptoms of grave infection due to urinary infiltration; this, very voluminous, was incised, but the symptoms of infection persisted and the patient died. On autopsy an ulcerative lesion of the urethra was found, the urethra being obliterated by a collection of pus. Beneath this was a narrow conduit which lead to a pocket beneath the mucous membrane parallel with the urethra; there could be no question of a cyst as the walls had no epithelium, but the author believed it due to simple ulceration due to gradual necrosis of the subjacent tissue.

Delirium Due to Renal Tuberculosis.—Drs. Loumeau and Régis reported the case of a young woman committed to an insane hospital for cerebral trouble which was recognized as autotoxic. Examination lead to an operation for

nephrectomy and removal of a tuberculous kidney followed by complete recovery of mental health as well as physical.

A Case of Sarcoma of the Kidney.—DR. BRIN reported a case of large tumor of myxo-sarcoma of the kidney removed three months before.

A Case of Essential Hematuria.—DR. NICHOLICH.

Downes Instrument for Segregation of the Urine.—DR. NICHOLICH has employed this instrument since February, 1901, in 16 cases with 11 positive and 5 negative results.

DR. DORST has used the Downes instrument 3 times, twice unsuccessfully, because the bladder was sensitive, and he believes that for the successful employment of the instrument we must have the bladder of good capacity and not painful.

The Separation of the Urine from the Two Kidneys.—DR. LUYS.—There are now 3 instruments for the segregation of the urine. Neumann's, which is only applicable in women. Harris's, made of two portions, one the double catheter, which when open is separated by the portion inserted into the rectum in the male and the vagina in the female. Downes's instrument, which is only a modification of Harris's. The author has added a fourth on a new principle. There is no rectal portion. It consists of two metallic catheters and an intermediary portion of metal covered with a rubber chemise, which can be raised and made tense or lowered by means of a chain and forms a partition between the two catheters.

The instrument when closed has the form of a Guyon sound. Its caliber is about that of a 42 Benigue (21 F.). Sterilization is easy. Evacuation is assisted by means of a rubber hand bulb creating suction into two small bottles.

Rare Case of Tumor of the Fatty Capsule of the Kidney.—DRS. HARTMANN and LEGENE. The case was one of a lipo-myxo-sarcoma of large size.

Normal Anatomy of the Supra-renal Capsule.—DRS. ALBARRAN and CATHELIN. The authors describe a situation of the supra-renal capsules which differs from that ordinarily accepted. They are situated normally between the kidney and the vertebral column above the pedicle of the kidney.

Compression of the Ureter by Inflammatory Lesions of the Adnexa.—DR. BRIN related a case of a woman with inflammatory condition of the uterus and adnexa on both sides, pressing on the ureter causing nephritic colic and renal retention. After operation of total hysterectomy the patient passed spontaneously a small calculus. The author believes that the compression upon the ureter caused the formation of the calculus, which being arrested at the point of narrowing increased the existing symptoms.

The Importance of Cystoscopy in Diagnosis for Operative Procedure and Calculous Anuria.—DRS. PASTEAU and VANVERTS. When it is necessary to operate for calculous anuria it is often difficult to know upon which kidney to operate. The history as to the side which gave localized pain is deceptive, and often examination of the kidney region gives no assistance. The authors, in a personal case, found increased heat and muscular tenseness situated on the left side, while the cystoscope revealed blood coming from the right ureter. It was the right side on which trouble was located and was the side operated.

Exploration of the Ureter and Pelvis by Natural Route.—DR. PASTEAU. Catheterization of the ureters made with bougie a boule analogous to those em

ployed for diagnosis in the urethra, permits the diagnosis of strictured conditions. In difficult cases a fine bougie or a bougie with bayonet may be indicated.

The discovery by ureteral catheterization of calculus in ureter or pelvis is a clinical rarity which cannot be counted on.

The catheter *en gomme*, when it has been in place a long time may give valuable information as to abnormal curvatures of the canal.

The length of the ureter in the living is 23 centimetres in woman and 24 or 25 c.m. in man. The employment of catheters graduated in centimetres when introduced under control of the eye may give exact location of lesions.

Small renal retentions may be diagnosticated easily but necessitate particular precautions in technique.

NEW YORK DERMATOLOGICAL SOCIETY.

304TH REGULAR MEETING, MARCH 25, 1902.

JAMES M. WINFIELD, M.D., *President.*

A Case of Hemorrhage Followed by Xanthoma Palpebrarum.—Presented by DR. JOHNSTON.

Woman of Polish birth, aged forty-four. Has pyorrhea alveolaris with consequent loss of teeth. Has been under the care of neurologists for some time. When I first saw her, she had asymmetrical areas on arms and back of rather persistent, angioneurotic edema, which has entirely disappeared. She has had pain in both arms and they are somewhat anesthetic to pain and temperature. The musculature is also affected. The hands are in a partially flexed position and have a somewhat claw-like appearance. She is suspected to have a proliferation of glia in the neighborhood of the central canal of the spinal cord in the cervical region. There have been no distinct symptoms of syringomyelia.

The disease of the lids began nine months ago. The spots began on the upper left lid near the inner canthi in the form of small yellow spots which spread and assumed a red-brown tinge. A month later, the condition appeared in the same situation on the right side. Since then the patches have gradually spread until they are roughly an inch long by half an inch wide. At present, the older portions have the chamois color of xanthoma, while the newer are red or brown as in hemorrhage. The latter are punctate and are accompanied by slight itching when they first appear. They do not fade on pressure. There is no elevation and no thickening in the skin.

A Case of Atrophic Neurosis.—Presented by DR. S. SHERWELL.

Miss M. X., act. twenty-five. Born in Ireland. Father died of injury, and mother of phthisis—is delicate, thin and nervous, but has on the whole enjoyed fairly good health. Suffered from childhood with evanescent erythematous eruptions on face. The present lesion came on about twelve years since. Came on at first as slightly raised distinct white spots lenticular or about the size of very small peas increasing somewhat in size gradually and thereafter becoming atrophied, and finally resulting in the condition now shown, which is in brief a collection of these atrophied spots extending from over the outer third of the left clavicular region straight across to the middle third of the right and also across

the scapular surfaces on both sides. A condition somewhat like striate atrophy is manifested near the throat, or in center of the first described group of lesions, but from her description, they seem to have been separate lesions which became merged into one or more of these striæ. There are no subjective symptoms as of pain or pruritus. A thin scale of dead epiderm tightly adherent is manifest for a time, this being rubbed or picked off, only the glossy and dead white and somewhat depressed surface is in evidence. The conditions seem to spread all the time, but very slowly with each year.

The case is presented to the Society for diagnosis, as it seems neither histologically or clinically to be exactly like morphea, the disease it most resembles.

DR. S. LUSTGARTEN said that for the past two months he had had under treatment a middle aged woman presenting a similar condition, which had puzzled him greatly. Apparently the initial lesion had been a lenticular infiltration of the skin, which had soon developed in the center a tiny horny crust. This was comparatively quickly followed by atrophy, occasionally pitted, but usually a shiny scar. No name had been given to this disease, yet it deserved one, as it seemed to be a clinical entity.

DR. G. H. FOX said that he had only seen one similar case. In that one he had been inclined to make the diagnosis of morphea, but had hesitated because of the umbilication observable even in the newest lesions.

DR. J. C. JOHNSTON thought the case was entirely identical with the one shown to the American Dermatological Association in Chicago last summer by Dr. Montgomery, except that the streaks in that case ran up and down as well as around the neck, and did not present the perifollicular character presented by the case now under consideration.

DR. S. SHERWELL said that he had had one similar case, occurring in a boy of ten or twelve years. It began with a tiny scale, which when removed left an atrophic spot. He had a theory that there was a peculiar underlying neurotic condition, possibly explained by the fact that the woman was a weed of an aristocratic type—in other words, that this was the result of breeding in-and-in.

A Case of Lupus Vulgaris with an X-Ray Burn.—Presented by P. A. MORROW.

The patient, a woman æt. about forty, first came under observation in 1898. She had at that time exuberant lupus tubercles covering the entire upper lip to the root of the nose, also the vermillion border and inner surface of the lips. There was a lupus covering the greater portion of the surface of the right cheek, also a large patch over back of right shoulder; this latter was freely excised and there has been no return. The disease on the lip and cheek has been apparently cured two or three times by the galvano-cautery, but after a certain period the tubercles would again crop up. The X-ray treatment which was applied only to the patch on the cheek, was begun January 13, and up to March 3 she had received ten or eleven treatments. The exposures were from eight to fifteen minutes in duration at a distance of three and one-half to ten inches.

On March 3 a marked redness was observed over the region of application and the treatment was discontinued. For the next three or four days there were a number of blebs over the surface exposed; these collapsed and were wiped away, showing a burn apparently superficial, quite painful and with no disposition to heal.

A Case for Diagnosis. Presented by DR. GEORGE THOMAS JACKSON.

The patient was a young woman having an affection of the face that had

existed for two years. It began at about the middle of the right cheek and had gradually spread all over the right side of the face. For the past eight months the right eye was closed by a chronic œdema of the lids. The cheek was firm, swollen, and red, and gave to the hand the impression of heat. No pain nor tenderness was complained of.

DR. H. H. WHITEHOUSE said that there was apparently some lymphatic obstruction in this case, but the cause of this was not obvious from a hasty examination.

DR. L. DUNCAN BULKLEY was inclined to think that it might be sarcomatous, as such sluggish growths were not unknown. The glands were swollen below the neck. There were several cases on record of diffuse flat sarcoma of the skin.

DR. H. C. KLOTZ concurred in this opinion.

DR. J. A. FORDYCE said that it was a unique case, and the diagnosis could hardly be made except by further pathological study.

DR. J. C. JOHNSTON thought a tentative diagnosis of new growth was justifiable, and that it was probable that it originated in the parotid. If this were the case it was more probably an endothelioma than a sarcoma, and this, too, would explain the peculiar mode of growth observed in the case. Sarcomas show a tendency to become lobulated, while endothelioma remains flat.

A Case for Diagnosis.—Presented by DR. J. A. FORDYCE.

The patient, a woman, 32 years old, stated that her trouble had begun six years ago in the lumbar region without any subjective symptoms other than itching. Since then lesions had appeared in the axillary spaces, between the breasts over the lower part of the abdomen and thighs. The spots are lenticular and of practically uniform size; they are scaling and depressed, and present slight atrophy. The brownish-red color of the spots does not entirely disappear on pressure.

DR. S. LUSTGARTEN said that the character of the infiltration reminded him somewhat of the lupus infiltration in its softness and color.

DR. G. H. FOX said that if the lesions had all been in one group hardly any one would have hesitated to call it lupus.

DR. L. D. BULKLEY said he was inclined to regard it as diffuse lenticular lupus vulgaris.

A Case of Specific Onychia.—Presented by DR. O. H. HOLDER.

The patient was a man in whom all of the nails of the fingers and toes had been affected. The trouble began as a well marked erythema near the base of the nail. He had been treated for about six weeks by the application of the yellow oxide ointment to the nails. He had contracted syphilis two years and a half ago, and had been under active treatment all the time.

A Case for Diagnosis.—Presented by DR. O. H. HOLDER.

The patient was a young man who had been treated with arsenic for about three weeks past. The present eruption began on the back about eighteen months ago, and had slowly extended. It had been associated with considerable itching, and at times the eruption was more vesicular than at present. He is a tailor by occupation. Dr. Holder thought it probable that the case was one of dermatitis herpetiformis.

DR. J. C. JOHNSTON thought it was a case of dermatitis herpetiformis. There was little or no pus, and the pustules usually found in folliculitis were not present.

DR. G. T. JACKSON concurred in this diagnosis.

DR. H. H. WHITEHOUSE said that he was of the same opinion, although the localization was somewhat peculiar.

DR. J. A. FORDYCE was inclined to think it was an infectious folliculitis because of the manner in which it spread.

Extensive Epithelioma of the Left Eyelid; Treated by The X-Rays.—DR. L. DUNCAN BULKLEY presented this case. (MS).

Mrs. S., aged 50, had first a small elevation beneath the left eye fully twenty years ago. This had gradually increased in size, involving new tissue up to the time when first seen, February 12, 1902, and had had practically no treatment until one year previously, when it was subjected to actual cautery.

When first seen (photograph presented) the whole of the lower lid was gone and toward the nose there was an ulcerating mass extending downward about an inch, and evidently extending back into the ocular cavity.

As excision or cauterization would certainly involve the loss of the eye, she was subjected to X ray treatment by Dr. Geo. A. Lawrence, and had had ten sittings, the last being this day. (Details given in Dr. Lawrence's letter given to Dr. Ludlow.)

At present the ulceration is seen to be entirely healed, with only a few nodules at the upper portion. She will continue the treatment.

Mrs. E. S., age 50 years, epithelioma of lower eye-lid involving lower portion of cornea and sclerotic coat of eye (L.). Ten years ago began to give her trouble and to extend, and past year extending and penetrating very actively. No pain at any time. Lower eye-lid much eroded, sclerotic coat of eye much reddened and lower part of cornea opaque interfering somewhat with vision. Began X-ray treatment, February 17th, tinfoil mask of three thicknesses covering all other portions of face.

February 17, '02, exposure of 15 minutes. Target 28 c.c. distant. Resistance of tube 6 c.c. No pain or discomfort.

February 20, '02, exposure of 15 minutes. Target 28 c.c. distant. Resistance same. No pain or discomfort. Slight pus formation to-day. Lower portion of sclerotic red and lid also reddened.

February 27, '02, similar exposure. Some serous discharge. Improving.

March 6, '02, similar exposure. Slight discharge of serous fluid, but healing up. Included small area on upper lip; right side in exposure to the X-rays.

March 11, '02, similar exposure for 12 minutes. More or less serous discharge from eye, but healing.

March 13, '02, similar exposure for 12 minutes. Crusts forming on spot on upper lip of right side, as well as on sclerotic coat of eye and lower eyelid. More or less serous discharge continues.

March 15, '02, same treatment for 12 minutes, with target 30 c.c. distant. Still considerable serous discharge from eye, but crusting and healing continuous.

March 17, '02, same treatment for 15 minutes, with target 30 c.c. distant. Discharge about same. Seems to be healing up from periphery and becoming more circumscribed.

March 25, '02, same treatment for 10 minutes, with target 40 c.c. distant. Considerable more discharge and pain following last treatment, but disappeared in three or four days and now cleared up.

DR. J. A. FORDYCE thought the result was very good, and that if the treatment were persisted in the patient would eventually recover. Mention was made of a

case, previously presented, in which the progress under the X-ray treatment continued to be satisfactory.

DR. G. H. FOX said that the improvement in this case was undoubted, and marked, but there were so many other ways, perhaps simple, which might have given just as much improvement that one should refrain from drawing conclusions until the case had progressed further.

DR. J. M. WINFIELD said that a case having a very similar localization was now being treated by the X-ray in the Kings County Hospital. The improvement was as marked as in the one under consideration. In another hospital he was himself treating an epithelioma of the cheek by this method, and it had already shown distinct improvement. The ray had been applied only three times.

DR. BULKLEY said that the treatment would be continued for some time longer, and he expected the lesions would entirely disappear.

Broken Hair in a Case of Alopecia Areata.—DR. L. DUNCAN BULKLEY presented a lady illustrating this condition. The alopecia began after an attack of nervous prostration three years ago. The hair disappeared in patches at first, and this rapidly spread until the scalp was entirely denuded. The hair then grew in perfectly white. Under the persistent and free use of iron the hair gradually darkened. After another attack of nervous prostration the alopecia returned, and was succeeded by another growth of gray hair. The hair came off by breaking about one-sixteenth of an inch from the scalp, leaving a condition which, on palpation, closely simulated that observed in ringworm.

DR. J. A. FORDYCE said that he had seen this condition of broken-off hairs before.

DR. P. A. MORROW said that he, too, had seen the hairs broken off in this way, and had noted that the case might remain stationary in the so-called "cadaveric" condition for many weeks or months. He would not attach the same importance to the effect of the iron upon the coloration or the hair that Dr. Bulkley seems to do. In almost every case of alopecia areata the hair comes out white, but it is spontaneously restored to the natural color.

DR. S. SHERWELL said that he could endorse this last statement of Dr. Morrow regarding the restoration of the color of the hair.

DR. G. H. FOX said that it was hard to find proof that either the carbolic acid or the iron had had any special effect.

DR. G. T. JACKSON said that this broken-off condition of the hair was not uncommon, but it should not lead to the diagnosis of ringworm, as there was never any redness nor scaling, nor crusting of the scalp, as there always was in ringworm.

DR. H. H. WHITEHOUSE thought this stubbed condition of the hair was rarely seen except in cases in which the scalp is entirely denuded; those seen in the patchy form indicated that the disease was still progressing. He had almost always found that the hair returned fine and of a light color, but recently he had seen a case in which rather coarse, dark hairs had grown out of the bare spots.

Erythematous Syphilide with an Old Seborrheic Eczema.—Presented by DR. L. DUNCAN BULKLEY.

The patient was a man of twenty-six years, showing an erythematous syphilide combined with an old seborrhoic eczema.

DR. P. A. MORROW said that the two diseases seemed to be absolutely distinct, neither eruption influencing the other.

DR. E. B. BRONSON said that to him it appeared as though in many places

the psoriatic lesions had become the sites of syphilitic lesions. He had observed the same thing in other psoriatic patients that also had syphilis, *i.e.*, a special tendency in the patches of psoriasis to become affected with syphilitic infiltration. Others have also noted that tendency.

DR. S. LUSTGARTEN thought that a number of psoriatic lesions presented the character of the syphilitic lesions—in other words, that symbiosis was present.

DR. G. H. FOX said that, to his mind, there were some undoubted psoriatic lesions and some undoubted syphilitic lesions, and inasmuch as squamous syphilides look very much like psoriasis there were some lesions in which it would be impossible to say which disease it was.

DR. BULKLEY said that he had exhibited the case as a seborrhoic eczema. The lesions were not at all characteristic of psoriasis, being more inflamed and crusted as in diffuse seborrhea. He had been first shown this by Unna, and he believed a good deal of the eruption would disappear under resorcin, a thing which psoriasis would not do. There was almost nothing of the original eruption on the elbows or flexor surfaces.

DR. KINGSBURY said that the squamous lesions he would look upon as seborrhoic eczema if he had seen them apart from the specific lesions.

A Case of Dermatitis Following Use of a Hair Dye.—Presented by DR. BULKLEY for DR. KINGSBURY.

The patient was a woman who had used a hair dye for about one year. The dermatitis of the face and scalp developed about two months ago.

DR. S. SHERWELL said that he was not convinced that the dermatitis in this case had resulted from the use of the hair dye. It was hardly probable that the hair dye would give rise to such a lasting eruption.

DR. P. A. MORROW said that there was a hair dye containing hydrochlorate of paraphenylene diamin which gave rise to intense dermatitis, sometimes persisting for six or eight weeks after the application. In a case of this kind that he had seen the eruption was not limited to the scalp, but was situated upon the anterior portion of the chest and the back of the neck. Where the hair dye had been applied there was a vesico-pustular eruption with crusts. On the cheek it was very like an erythematous eczema, only less diffuse and more patchy. He knew of no other agent which, when applied to the skin, produced such a persistent dermatitis.

DR. LUSTGARTEN said that he had seen a number of similar cases, one produced by a proprietary preparation. All of them had persisted for a considerable time.

DR. G. T. ELLIOT said that he had seen a number of such cases, and in his experience they were quite common. He was inclined to believe that the chief mischief was from the mordant used rather than from the dye itself.

DR. BULKLEY said that the fact that the dermatitis did not develop until after the dye had been used for some months was no argument against its having been the cause of the dermatitis.

DR. MORROW said that there might be absorption of the poisonous dye by the hair shaft, and there might, therefore, be some continuous absorption. In the particular case under his observation there was very little improvement until he had had the patient's mustache and hair cut close.

Case of Pemphigus.—Presented by DR. MORROW.

The patient was a woman aged 50, of good family history. She had been vaccinated February 15th

The present eruption began to appear about March 1, in the form of bullæ, which, according to the patient's statement, "popped up from the skin like green grapes." When she came under my observation, March 17th, the eruption was especially marked on the dorsum and palms of hands, on forearms extending above the elbows mid-way to the shoulder, on abdomen around the vulva and inner side of thighs, and nape of the neck extending down between shoulders, also upon the uvula and roof of the mouth. The lesions were about the size of a marrow fat pea or larger—some on the inner side of the thighs were the size of a pigeon's egg—they were filled with a straw-colored fluid and thickly clustered, almost confluent, especially upon the forearms. They seemed to spring up from the sound skin, without antecedent inflammatory change. After the collapse of some of the larger bullæ there was in some places a tendency to the formation of smaller bullæ around the central lesion suggesting erythema iris in their concentric arrangement. The eruption came out in successive crops and was extremely pruriginous. The patient complained of headache, inappetence and general malaise, also from inability to sleep.

DR. LUSTGARTEN said that the eruption was of short duration and presented the symptoms of herpes iris rather than of pemphigus. He would especially call attention to the erythematous lesions in the palms.

DR. FOX said that the fact that the bullæ sprung directly from the healthy skin would exclude herpes iris.

DR. C. T. DADE thought the case was one of multiform erythema, and that the lesions on the wrist were very typical of herpes iris.

DR. BULKLEY said that there was certainly a good deal of erythema around the lesions, and hence the diagnosis of herpes iris was quite possibly correct.

DR. FORDYCE said he had had in the City Hospital recently a case of pemphigus in which after the lesions had disappeared the patient had developed a multiple neuritis. This had occurred several weeks after stopping the use of rather large doses of arsenic.

DR. MORROW said that at first he had thought the case might be one of bullous erythema, but after watching the mode of development of the lesions he found that it did not at all correspond with the evolution of multiform erythema. There was no preceding erythematous or papular stage; as the patient had well expressed it, "they sprung up like green grapes." The lesions were very large, and there had been absolutely no suggestion of herpes iris until the breaking down of the bullæ. On the round spots marking the bases of the bullæ a number of smaller lesions had sprung up, and these certainly suggested erythema iris, although he could not conceive of that affection developing in such a manner.

Syphilitic Alopecia Resembling Alopecia Areata.—Presented by Dr. P. A. MORROW.

The patient was a young married woman, æt. 22, presenting a peculiar form of syphilitic alopecia resembling alopecia areata. The patches were round, or oval, and entirely smooth and quite characteristic of alopecia areata. She had been under observation several months and gave no sign of syphilis with the exception of a pigmentary syphilide of the neck. No history of syphilitic infection was obtainable from the patient or her husband, except possibly the occurrence of a lesion upon the ungual border of the left ring finger. This she stated existed several months, and was attended with enlarged glands above the elbow and in axilla of left side, but at present there were ulcerative lesions of the tonsils which were almost certainly specific.

DR. FORDYCE said that the pigmented lesions on the back of the neck were highly characteristic.

DR. BULKLEY also thought the alopecia was quite characteristic, and should not be confounded with alopecia areata.

DR. ELLIOT said that every one of the spots was atrophic and separated by normal skin from the other lesions. The pigmented syphilide on the neck and the gumma in the throat were additional evidence of the correctness of the diagnosis.

DR. DADE accepted the diagnosis.

DR. FOX said that there could be no doubt about the patient having had syphilis, but he doubted if the alopecia was due to syphilis because he had seen the same condition very often in persons who had not had syphilis. He hoped the case would be presented in the near future so as to settle this point.

DR. LUSTGARTEN said that the picture presented was that of syphilitic alopecia in connection with a pronounced leukoderma. He was inclined to look upon it as syphilitic.

A Case for Diagnosis.—Presented by DR. L. DUNCAN BULKLEY.

The patient was a boy of SIX years, who last August developed a small inflamed spot on the centre of the lip. This gradually enlarged and was associated with infiltration. The tentative diagnosis that he had made was scrofulous or tuberculous eczema. The father had died of acute tuberculosis.

DR. H. H. WHITEHOUSE said that the appearance of the case was like that of lupus vulgaris.

DR. GEORGE THOMAS JACKSON said that the boy had been sent to him last fall, in consultation, and at that time it resembled a large gummatous syphilide. Antisyphilitic treatment was employed without benefit. The child had some illness, for which he was admitted to the hospital where under simple boric acid dressing the improvement was very marked. At the present time it certainly appeared to be a tubercular affection.

DR. LUSTGARTEN considered the case to be one of lupus vulgaris.

DR. FORDYCE said that he saw the case last November, and suggested the diagnosis of tuberculosis, though at the time it resembled a gumma.

DR. BULKLEY suggested that a distinction should be made between tuberculosis cutis and lupus. He would consider the case one of localized tuberculosis upon an eczematous basis.

A Case of Psoriasis Treated by the X-Ray.—Presented by DR. C. W. ALLEN.

The patient was a young man, first seen by him on February 14. The eruption involved the entire body. He had applied the X-rays to the back only, using chrysarobin over the whole body. Distinct improvement was evident over the area subjected to the X-rays, when compared with the other regions not thus treated.

NEW YORK ACADEMY OF MEDICINE.

Section on Genito-Urinary Surgery.

Wednesday Evening, March 19, 1902.

John Van der Poel, M.D., *Chairman.*

PRESENTATION OF CASES AND SPECIMENS.

A Case of Possible Infection of Syphilis from an Instrument in the Person of a Physician.—Dr. Frederick Griffith.

The history of a case of possible innocent infection of syphilis in the person of a physician at present under my observation is of importance as an instance illustrating the precaution necessary in handling syphilitics.

H. is a physician who had the subject of the following record under treatment.

A., a male, aged eighteen years. A shirt-maker by occupation observed a sore on his frenum after intercourse which had taken place upon two separate occasions four and six weeks previously. Induration was present, later developed glandular enlargement in both groins, in the post cervical chains and in the epitrochlears.

Alopecia occurred but there was no pathognomonic eruption. Chronic sore throat came on with bilateral enlargement of the associated lymphatics about one month after the appearance of the initial lesion. Small mucous patches appeared subsequently upon the tip and under side of the tongue and at the bottom of the sulcus between the lower jaw and lip. A gradual enlargement of both tonsils occurred at his time.

With the appearance of the secondary lesions antisyphlitic treatment in the form of the protiodide of mercury, grain one quarter three times a day; increased to half a grain; reduced and continued in doses of one-quarter grain four times daily was instituted, and save for the tonsils which remained of constant size, general bodily improvement took place.

Swallowing and breathing being interfered with, double tonsillectomy was performed four months after the throat symptoms appeared.

With the performance of the operation begins the interest in the personal history of the physician.

The instrument used was new and of Mathieu's spear pattern.

No pain was felt by the patient and but moderate hemorrhage ensued.

A moment after the patient had departed, H. took up the instrument to wipe it off previous to sterilization and in so doing pricked himself upon the ball of his left hand with the blood-stained spear of the instrument.

By means of squeezing, the application of a ligature and sucking comparatively free hemorrhage was produced from the pinpoint puncture.

No pain was felt at the time of the accident or subsequently. Seeing the wound an hour after the accident it presented to view a small punctured orifice and I simply advised watching. The wound healed entirely within a week and at the time I next saw it, by close examination a small pearly white scar was

apparently surrounded by a ring of epidermis which could be peeled off similar to a small ruptured vesicle.

Accepting that patient A.A. was suffering from syphilis, H., apparently should have demonstrated the innocuability of syphilized blood, the spearpoint being bloodstained according to the positive declaration of H.

It is now four months since the occurrence took place and no signs of syphilis have appeared in my professional patient.

Why he did not develope a primary chancre placing little value upon his measures of treatment at the time, is a difficult question to solve unless as has been put forth by some authors "that syphilitic poison introduced into a vein or a lymphatic vessel might give rise to constitutional syphilis instead of a chancre or a primary lesion."

It becomes a very fine point in the pathology of infection of an individual by syphilitic virus to determine just how the poison is absorbed; that it does not remain localized during the period of chancre formation is attested by the results of a number of surgeons who have performed excision of this lesion without securing immunity from secondary symptoms. Whether the next capillary pulsation succeeding the introduction of the virus or syphilitic germ if such be the cause of this dread disease, to an abraded surface, carries the poison into the general circulation to become elaborated during the period of incubation or whether absorption takes place more slowly through opened lymph-spaces, we cannot tell.

Sufficient time having elapsed for the appearance of a primary or secondary lesions in Dr. H.'s case I am led to believe that his efforts in his own behalf at the time of the accident were successful in throwing off the poison and that he has demonstrated that there must be an appreciable interval of time after the introduction before the absorption of syphilitic virus takes place.

With this deduction this report can have no better close than with a caution. Careful handling for their own personal protection of syphilitic patients by their medical advisers cannot be too often advocated. Instruments should be instantly boiled after use upon this class of patients.

Local treatment of mucous patches had best be made by employing wooden sticks as cotton applicators and tongue depressors; both are cheap and can be destroyed by burning.

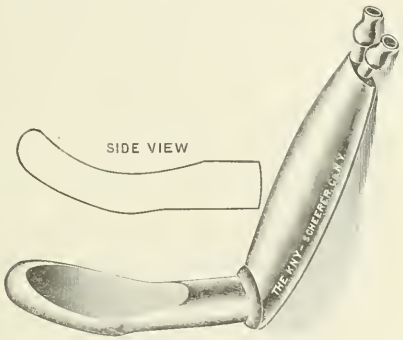
DISCUSSION.

DR. OTIS.—I would say in regard to these cases, I have on two occasions—one on a circumcised which I was performing myself for a concealed chancre under the prepuce, pierced my finger with the needle which was being used at the time, and some years later I put my hand on a knife with which another surgeon had removed a hard chancre from the prepuce. It was the time at which we were removing the initial lesion considerably, and on the first occasion there was nothing done except to squeeze it out and suck it and use a strong solution of carbolic acid. The second time I immediately put nitric acid into the wound and a little about it, of as much. It was followed by no symptoms in either case.

DR. [illegible].—I have cut myself at least a few times when operating on syphilitic cases, when doing a perineal section on a syphilitic individual who had an ulcer [illegible] the time I cut my finger. It happened to be my right finger and I have cut across the finger I subsequently passed into the perineal wound, and I do not remember I took any special precautions except to disinfect it as

one ordinarily would do. On two other occasions I have pricked my finger quite deeply with needles while examining or operating on syphilitic individuals, without any subsequent effect. I am rather inclined to believe, as has been claimed by many writers, that the blood of a syphilitic will not give contagion.

Prostatic Cooler (Psychophor).—Dr. Van der Poel.—This is a modification of one invented by Dr. Levine of Berlin. The advantages of it are first, that if found necessary it can be applied by the patient himself, and second, it can be applied, and is employed in a sitting posture, the patient's perineum resting upon the flat portion which reaches over the edge of the chair where the attachments of rubber tubing for the flowing in and out of the water are made, and



from where they can be controlled by the patient. The convex portion fits over the convexity of the prostate. The great advantage of it is, that it can be applied with the patient in the sitting position instead of compelling him to lie down, in which there is always more or less difficulty in keeping the tube against the prostate without holding it there. This one, once put in position with the patient sitting upon it, can be kept there.

Prostatic Douche Tube.—Dr. Ramon Guiteras.—This is a tube which has a single, not double current, and a simple wire at the end. It may be very old—whether this is so I do not know. I found the tube in a store about three years ago and had the wire put on the end—simply the inflow. It goes down in the prostatic urethra, irrigates the prostatic urethra, the anterior urethra and the bladder. By pressing it you may force the water along the sides of the tube into the anterior urethra or the posterior urethra and it will probably reach the bladder, or you can push it into the bladder, and after filling it allow it to escape again.

An Elongation for the Finger for Prostatic Massage and Stripping of the Seminal Vesicle, devised by a Physician of Louisville.—Dr. Valentine. —At the first glance it struck me that the instrument was the most desirable one of those which had been offered for the purpose of increasing the length of the finger. I, however, was doomed to disappointment. I found that in attempting massage or stripping of the seminal vesicle that the instrument doubled upon

itself and I got no extension whatever. The fault in my result may be that I had not read the author's technique; in fact, he has not published it yet. Perhaps I am doing an unfair thing in anticipating him in issuing it.

CASE OF MULBERRY CALCULUS.

DISCUSSION.

Dr. Van der Poel.

The specimen I have to show is a particularly fine example of mulberry calculus, from which, one of the radiographs shown at the last meeting, was taken. As I remarked then, there was nothing of note either in the symptoms or history of the patient excepting that he gave a marked alcoholic history, preceding the period when the symptoms were first noticed. The diagnosis of oxalate of lime was made from its cystoscopic appearance, but the section as shown, proves it to be mostly composed of uric acid, with an oxalate of lime nucleus and circumference. The weight, 58.5 grammes. Although considerable strangury and pain were present, there was but little cystitis, and the removal was by the suprapubic method, with drainage through the urethra. The bladder wound was entirely closed as was also the skin and other tissues, excepting a small portion at the lower angle. The sutures were removed on the fourth day and the catheter on the seventh, at which time the patient would have been up and about, had it not been for a hypostatic pneumonia which developed from a bronchitis immediately after the operation. As presented to-day, the fourteenth day, the wound is entirely closed, and solid.

DR. OTIS.—I was very much pleased to be present at the operation and I am very glad to hear that the patient has made such a good recovery.

DR. JOHNSON.—I would like to say I regard it as a very beautiful specimen and rather regret that Dr. Van der Poel did not bring the radiograph of that shown, which I was fortunate enough to see the other day, and which illustrates quite well one or two things I shall speak of in my paper. You will see in the radiograph the different structures, the substance of which the calculus is composed is very clearly shown, and one is more easily penetrable than the other. The little spaces I think are filled with uric acid, if I am not mistaken.

The Diagnosis of Renal Calculus.—DR. A. B. JOHNSON read a paper with this title.

He spoke of the very great difficulties of establishing a positive diagnosis in these cases by ordinary methods of examination. The symptoms were often anything but typical in many instances and it was rare that a stone could be palpated through the abdominal wall.

A number of other conditions might produce precisely the same subjective symptoms and the same changes in the urine, including renal hermaturia of all varieties.

After describing briefly the signs and symptoms produced by calculi and the changes produced in the kidney and ureter by their presence, together with the various methods of examination in ordinary use, the X-ray diagnosis of renal calculus was discussed at some length.

The difficulties and limitations of the method were described. These depended chiefly upon the somewhat erratic behavior of X-ray tubes and upon the

fact that with the best apparatus it was very hard to obtain pictures of stout persons of such quality that the presence of stone could be excluded.

In the case of pure uric acid stones the reader said that the shadows were faint and he thought it doubtful if such stones could be demonstrated in fat people unless the stones were of some size.

Fortunately pure uric acid stones were not very common and a very small admixture of calcuum oxalate rendered the shadows cast by such stones much sharper and denser.

The reader said he had examined some 126 cases. Stone had been demonstrated in 26 cases. Once in an early effort he had said a stone was present whereas none was found. Once stones had been passed per urethram although not shown in the picture.

He had, however, succeeded in showing some very small stones of mixed uric acid and oxalate even in stout persons.

The smallest stone of this kind he had been able to demonstrate weighed a little more than half a grain.

Several prints were shown illustrating some of the difficulties of the technique and others showing the varying results by the use of tubes of different vacua and different times, in like and unlike stones.

A point was also shown demonstrating the degrees of permeability of various types of calculi, and several negatives were shown in which the presence of renal calculus was easily seen. Their diagnosis had been verified by operation.

DISCUSSION.

DR. F. TILDEN BROWN.—Mr. President: I have been very much interested in this valuable contribution to an interesting subject given us by the reader of the paper. I have very little to say. I can refer to one or two cases which have been instructive to me. I do feel, however, despite the amount of disparagement the writer of the paper maintains, from certain European quarters and from certain sections in this country, I do feel that there is no such valuable agent for the detection, for the clearing up of the diagnosis of stone, as by means of the X-rays, and what I have seen of Dr. Johnson's work in connection with some cases of my own, besides the plates he has shown me of other cases, has led me to feel very confident that I would be apt to get a quite positive diagnosis from Dr. Johnson's method of examination provided the patient were willing to undergo the repeated examinations at several intervals in case uric acid stones of small size were the offending substance.

I might make allusion to one case which Dr. Johnson and I have seen together and whereas we neither of us have anything positive to say about the case, I think it would be interesting to this section, though it was mortifying to me to think that a suspicion of the probable state of things had never occurred to me. A gentleman of some sixty odd years of age, heavily built man, was referred to me as having prostatic trouble. I examined his prostate. He complained of exquisite sensitiveness over one point on the right lobe—and I want to say that the prostate was uniformly larger than normal for a person of his age. He was exquisitely tender at a point over the right lobe of the prostate. Compression of this resulted in nothing more than the outpouring of a great many corpora amylacea, and he said he was relieved. Some such process as that was gone through with at intervals of four or five months and the patient returned in better spirits and health; but he complained bitterly as ever of annoying sensations

referred to the perineum, inability to sit down without pain in the ischia, inability to take any exercise, and a sensation as if some small bug were traveling in the deep portion of his urethra or the neck of his bladder or prostate. He felt quite certain there was a concretion in his prostate and he was unable to understand why he could press so firmly on his prostate without hurting himself very much and could never sit down, even on a soft sofa or chair, without discomfort, unless he had his pillow with him, and even then it was always attended with discomfort. He asked whether an X-ray picture would show if he had anything in the prostate or in the ejaculatory ducts. I told him I didn't know. I thought not. I did not know what shadow would be cast by such concretions but rather inferred that they would be very trifling. He wanted to try, and I introduced him to Dr. Johnson, who took a picture which showed a small concretion, presumably in the lower part, perhaps lodged an inch or an inch and a half of the right ureter and another small concretion perhaps 2½ or 3 inches up in the left ureter. Dr. Johnson naturally wanted to verify this and there was opportunity of doing so some three weeks later, when he got exactly the same effect. In that case it had never occurred to me that the patient was suffering from a possible calculus in the ureter.

Another case of interest which Dr. Johnson cleared up for me was in the case of a young woman I showed before this society some four years ago I think, where the kidney had been removed in conjunction with a pyelo nephritis and subsequent hemorrhage from the ureter, and in the first place I had detected the occlusion of the ureter by the ureteral catheter at a point 3 inches from the ureter mouth. I tried to dislodge, to move this calculus or pull it down, without success. It remained in place and nephrotomy was done to drain the kidney. Subsequently more bleeding came on and it was a question as to the cause of the bleeding, and whether nephrectomy was necessary; and the patient making a good recovery it seemed to me to be a matter of interest after about three years intervened to know whether that calculus was still in place. It was shown to be perfectly, just where it had been felt by digital examination in the peritoneal cavity and by measurement with the catheter in the ureter.

The only case to which I shall refer in one—I don't know whether Dr. Johnson knows anything about it. I don't know all the details of it, but it was a patient who was sent to me—the man was about fifty, who was supposed from his clinical manifestations to have right renal calculus. I think the fact of a negative report from some radiographs taken in one of the prominent hospitals in this city was the reason the patient was sent to me to be examined. The evidence showed that the right ureter was abnormal to a slight degree and in connection with the clinical manifestations it fairly suggested renal calculus. The kidney was opened and the calculus was found. I do not know what the nature of the calculus was.

DR. ORTH—Mr. President: I would like to say in regard to the diagnosis of kidney stone that I consider that the X-ray is without any doubt whatsoever the most valuable aid that we have in locating stone in the kidney, and it not only demonstrates the presence of stone positively, but also demonstrates in what portion of the upper urinary tract it is situated. In order, however, that it should be of value the apparatus should be of the very highest quality and the operator should be an experienced radiographer. Where the diagnosis is positively established, where the presence of a shadow has been confirmed by a second radiograph, the diagnosis is practically a positive thing. In thin patients, of course, it is much easier than in stout ones. We must also take into consideration the

fact that a diagnosis of renal calculus by any other method is exceedingly dubious. I suppose pain is the most common diagnostic symptom in stone, and owing to the reflexes in this region it is one of the most unreliable signs that we could have. You see patients with kidney stones which give nothing but bladder symptoms, or symptoms which Dr. Brown spoke of. Pain is one symptom. I think that the use of the radiograph by a man of experience and with the best apparatus —a man who understands the difficulties to overcome and the way best to do so, is the most valuable aid that we have in the diagnosis of kidney stone.

Dr. Bierhoff.—I regret very much I had not the pleasure of listening to the entire paper because I am satisfied it would have been fully as interesting and valuable as the part I had the pleasure of hearing.

I agree with the writer of the paper, as well as with the preceding speakers, in their views that the radiograph is one of the most valuable aids that we have at present for the diagnosis of calculus, either in the kidney or ureter. I cannot admit, however, that the radiograph is always positive in its results or that we can always rely upon it. I can recall one case, which is known also to our Chairman, in which the X-ray in the hands of one of the most expert operators in this city, with possibly one of the most complete and perfect machines in the city, on two occasions in the examination of the same subject left us with a negative diagnosis. Further examination by another method led us to make the diagnosis of renal calculus. The operation showed several large renal calculi.

Dr. Erdmann.—I should like to ask if the radiograph apparently increases the size of the stone or not. The reason I ask the question is because I saw that case operated upon of which you showed the plate yesterday and the stone did not appear anywhere near as large.

Dr. Johnson.—It does.

Dr. Van der Poel.—About how much is the increase?

Dr. Johnson.—That is a very difficult question to answer. It depends upon so many things. In the first place one thing I have noticed, that in some pictures the shadow of the stone is elongated vertically; that kidney moved a little bit. I noticed that very markedly in the picture I took yesterday and again in a picture I took about two weeks ago. The shadow of the stone was much greater apparently everywhere than was the real stone. Another difficulty is that it makes the stone appear larger but not to the same degree in every case is that everybody's kidney is not just the same distance from his skin, and, of course, the further the kidney is away from the skin the deeper it lies from the body, the more its shadow is increased, and, of course, the difference in the distance of the tube makes a difference. If the tube were always the same distance it would, of course, exaggerate the stone that was always at the same distance from the body an equal amount; but everybody doesn't put the tube the same distance.

Dr. Van der Poel.—I asked that question because two radiographs I showed at last meeting of vesical calculus were but a slight enlargement of the stone. Of course, this rule that Dr. Johnson speaks of would not apply in that case.

Dr. Brown.—I should like to ask whether in estimating the probable position of stones in the ureter a landmark could be placed—a button in the rectum or something of that sort, just above the prostate, so as to get some indication of the relative position of ureter stones.

Dr. Johnson.—That would be very simple.

Dr. Griffiths.—Dr. Johnson, in his statement of technique, regards a screen as no protection. I would like to ask the Dr. what he considers the cause of X-ray burning?

DR. JOHNSON.—I will have to answer as Lord Dundreary did, that is something no fellow can find out. I did not mean to say that the screen was no protection, but I did say—and it is generally believed—that it is not a perfect protection. It is probable that you are a little less likely to burn a person if you use a screen, but still burns have been produced although screens were used.

I do not know what the cause of X-ray burns is at all. It has been explained, as the gentleman who asks the question is probably aware, on a very large number of different hypotheses. One is that it is due to the static electricity generated in the skin; one that it is due to ozone generated in the skin; one that it is due to decomposition of the nitrogenous products in the skin and the formation of nitrates or nitrous acids or something of that sort, which produces gangrene of the skin; and there are some other explanations; but the main practical question is in what way to avoid burns. This, of course, hasn't much to do with the question of kidney stones. I have tried a number of things; tried screens made of gold leaf and produced a very good burn through the skin; paid $25 for the screen but produced burns just as where I used no screens. I also tried anointing the skin with lanoline and bought several pounds of lanoline and anointed the skin and produced burns. One way to avoid burns is to keep the tube way off from the skin and limit the amount of exposure on any given occasion.

When you are going to take a picture of kidney stones that are going to show stones you have to use a far greater amount of energy than in taking ordinary radiographs. The reason why most people fail to get pictures which show kidney stones and the reason why they make a negative diagnosis is because the apparatus they use does not permit them to get any picture at all of the body. They make a negative diagnosis because the plate doesn't show anything. In order to penetrate the body of a stout man you have to use a large amount of energy and the more energy you use the more apt you are to produce a burn. That is the reason why great care must be taken.

Obituary.

Hofrath Professor Doctor Moritz Kaposi died in Vienna, March 6, 1902. He was born in Kaposvar, Hungary, Oct. 23, 1837. In 1856 he went to Vienna to study until 1861.

He was taken up by Hebra, who recognized his abilities, and in 1866 was made *Docent* in Dermatology. In 1875 he was made a Professor and represented Hebra for two years. In 1881 he received the full charge of the clinic.

From a condition of comparative poverty and obscurity, by his work and his attractive personality he rapidly gained distinction in his special field. His name is indissolubly linked with that of Hebra, and it is perhaps due to the work of these two men that dermatology to-day holds the high position in medical science which it does. Among the most prominent dermatologists of the world are those who have been pupils of these two men.

Kaposi had published over 150 articles, among his most important works are "Das Lehrbuch der Hautkrankheiten," which has past through several editions, and translated into other languages, and "Pathologie und Therapie der Hautkrankheiten." Many of the forms of skin disease were first described and named by Kaposi.

Kaposi married the daughter of Hebra. One son is an assistant of Czerny.

Selections.

CUTANEOUS DISEASES.

Framboesia and Tinea Imbricata.—PROF. R. KOCH (*Arch. f. Derm. u. Syph.*, 49. 1902-3).

In his travels in the south of Africa and southern seas under a commission of the German Government to investigate malaria, the writer had an opportunity to examine many forms of skin diseases in the native people. He gives the following clinical description of the two disorders, as seen by himself:

(1) Framboesia is an infectious disease, which is transferred from one person to another. One attack endows the sufferer with immunity from further attacks. Children are the main victims of the disease, and they are intentionally exposed to the contagion in order to go through the disease quickly. The eruption is scattered in round patches, separate growths joining together, reaching various sizes from a pea to a quarter of a dollar. The eruption is always raised above the level of the skin, having the appearance of fungating granulations. The primary eruption looks very much like fresh variola pustules. The first appearance is of raised tubercles covered with epidermis which present marked pronounced concave apices. The largest tubercles are always deprived of their epidermis, secrete a purulent liquid and are covered with crusts. These disclose, after removal, a cushion-like granulating mass. In the same patient the whole development of the tubercles, all their transitory stages can be seen. The tubercles appear in various periods, always in decreasing number, till full immunity is reached, when their appearance ceases. This is reached in a period of time of from several months to a year. Usually children are affected only when the disease appears upon an island, the inhabitants of which have never suffered from it. Grown people also fall victims of the infection. Europeans according to the writer's statement never suffered from the disease, although they come in personal contact with the native people.

Tinea imbricata has often been seen by the writer. In small children the first appearance is on the breast, spreading in a circular form and then occupying entirely a large portion of the skin, not appearing in rings or circular patches as tinea tonsurans. A large number of inhabitants are affected. The disease does not influence the general condition of the patient. The affection never heals spontaneously.

The writer does not express a decisive opinion in regard to the question whether a chronic enlargement of the inguinal glands, noticed very often in the patients affected with tinea, is in relation to the disease.

Atypical Forms of Syphilis.—PROF. B. M. TARWOWSKY (*Russian Journal of Cutaneous & Vener. Dis.*, Vol. I., p. 11, Jan., 1901).

This interesting article brings to our consideration a very vital point of hereditary syphilis. According to Profeta's law a syphilitic mother can with impunity nurse her own child, without infecting the child with syphilis. Up to the present time there are only twenty-five (25) cases published as exceptions of this law. Accepting, then, the foregoing law as a guide when we are considering the welfare of such children, the question presents itself, does such hereditarily acquired immunity of the fetus last the whole of its life or a certain time only? Cases are reported where the acquired immunity lasted only a short

certain the children becoming infected with syphilis later in life, and others in whom the immunity was complete for life. This last fact gave great hope that through its natural syphilis will gradually disappear owing to syphilization.

Hutchinson, basing his deduction upon material gathered during his forty years of observation of syphilitic patients, concludes that such immunity is a very rare occurrence and that children born of syphilitic parents and having passed successfully the syphilitic stage, lose their immunity very early, mostly at the time of sexual development, and are prone to acquire syphilis in the same manner as healthy human people.

The form of syphilis acquired by the second generation of syphilitic patients, who have hereditarily acquired immunity is the subject of this article. The writer calls the first generation of syphilitic patients, families where the husband, wife or both have acquired syphilis, second generation, persons whose parents had acquired syphilis. This category presents first grade of hereditary syphilis. And the syphilis acquired by these patients he calls syphilis binaria, as two factors play here a part, the toxins of syphilis and later the syphilitic virus itself. This form of syphilis, as compared with the form of the usual acquired syphilis presents certain anomalies in its course. It may only limit itself to the primary manifestation of a hard sore with painless swollen glands. Under local treatment the hardness and glands disappear and no other manifestations of syphilis show themselves in the later period of life. This is the so-called abortive form of syphilis. The second form, *syphilis levis s. benigna*, has a mild course. The third form, *syphilis atypica proprie sic dicta* is entirely typical in its stages, presents anomalies in its course and may be mild and severe. There may be more forms of syphilis binaria, but the writer gives only here the account of cases and forms observed by him. A vast number of cases of syphilis binaria do not differ in any way from the course of usual mild syphilis. But one thing even a syphilis binaria developing in the ordinary way differs from hereditary acquired syphilis, namely, in its influence upon the progeny of the patient. The writer had the opportunity of watching three generations of patients afflicted with syphilis in twenty-five families. The first progeny of parents affected with syphilis binaria as compared with the first progeny of parents suffering with acquired syphilis, gives a double number of abortions, dead born children and of children dying in the first years of their lives. Dissimilar symptoms occur in more severe forms in children of the first category than in children of the second.

In conclusion, the author lays special stress upon the fact, that the cases upon which he bases his conclusions belong to well-to-do people, who did not neglect the disease but underwent a prolonged specific treatment with mercury and iodid of potash.

Changes of the Skin in Typhoid Fever (Typhus Abdominalis).—A. B. Strousse (*Russk. Vrach. Journ. of Cutan. & Ven. Dis.*, Vol. I., 1901, p. 1.)

In many cases of typhoid fever and typhus the palms and soles undergo a reddish change in color. The whim of the writer was to explain the cause of this change, to study the anatomo-pathological changes of the skin of those two diseases, typhoid fever.

The material was gathered from forty-two dying patients who died of typhoid fever without complications and from two who died of typhoid fever with nephritis.

Microscopical investigations lead him to accept the conclusion that a pig-

ment containing iron is deposited in the skin of typhoid patients partly in form of granules in the superficial layers of rete malpighii and partly in the form of a diffuse layer in the stratum corneum and in the deep layers of rete malpighii. This discoloration of the palms and soles is only met in thirty-four per cent. of cases of typhoid fever and is often seen in persons who died of other causes. During the attack of typhoid the elastic tissue of the skin and skin vessels is changed, a part of the elastic fibres is entirely gone, undergoing a granular disintegration, especially the elastic fibres of the skin vessels. These changes can be demonstrated in the third week of the disease and increase during the course of the disease.

Pityriasis Rubra (Hebra)—M. A. TSCHLENOV (*Russ. Jour. Skin and Venereal Diseases.*) Vol. II., page 3, 1901.

This contribution to the question of pityriasis rubra places the writer on the same level with the two epoch making works of Brocq and Jadassohn. From an exhaustive study of the question from Hebra's first description to the present time the author holds that pityriasis rubra is regarded differently by various medical schools, the French, American and Italian. The present tendency is to limit this group and simplify the nomenclature, recognizing pityriasis as a distinct disease, only enlarging at certain points the original clinical description of Hebra, and including many forms of erythrodermia exfoliativa of the French with drug eruptions. In England the term pityriasis rubra and dermatitis exfoliativa are used indiscriminately, only external symptoms of the disease being taken into account.

The writer's own opinion is that pityriasis rubra is a distinct disease, its features the same as those described primarily by Hebra, with some additions regarding its clinical picture and prognosis. He recognizes the existence of the acute form of exfoliative dermatitis of Wilson-Brocq, but questions the existence of its chronic form. As to erythema scarlatiniforme recidivans, it has nothing to do with pityriasis rubra. It is in many cases a drug eruption.

The writer reports three cases of his own, making forty-two cases in all. A detailed clinical description of one very interesting case is given, which during life had been regarded by some as a case of mycosis fungoides, owing to the superficial ulcers present upon the patient's chin. Careful observation and microscopical examination demonstrated that the ulcer presented a carcinomatous growth of the chin, and the autopsy revealed a carcinoma gelatinosum of the stomach with perforation.

Histologically, pityriasis rubra presents a primary affection of the epidermis with secondary inflammatory changes of the cutis, leading in the end to an atrophy of the skin. The etiology is unknown, the most acceptable hypothesis is a toxic origin of the disease. The prognosis is at present more favorable than in Hebra's time. A full and exhaustive literature is added to this thesis.

The Syphilitic Family and its Progeny—PROF. B. M. TARNOWSKY (*The Russ. Jour. Cut. and Vener. Disease.* Vol. II., 1901, p. 717.)

The conclusions arrived at by the writer are based upon the study of the clinical material gathered by him during his forty-two years of practice in medicine, during which he has had the opportunity of personally watching three generations of thirty syphilitic families. Some of the thirty families he was able to follow down to the fourth, even fifth generation. All the families belonged to the better class of city inhabitants, and the first and second generations, that is the generation which had *acquired* syphilis and the generation

which had hereditary syphilis were treated with mercury and iodin. Of the thirty families, twenty-two belonged to the pure Slav race and four of mixed race; Slav and German and French. In the city family syphilis is usually introduced by the husband, who acquires the disease before marriage. The hereditary syphilis showed itself in three forms: in form of hereditary syphilis, of dystrophic changes, and in the form of hereditary immunity. Parents with acquired syphilis may transmit one of the three forms to their offspring (first generation). The hereditary effect of the acquired syphilis is expressed in the second gneration of a syphilitic family by a large number of abortions, still-births, by children who either die in the first months after birth, or develop symptoms of hereditary syphilis or show anatomical and functional dystrophies. The hereditary acquired immunity of the second generation (Profeta's law) is with few exceptions only of short duration. The effects of hereditary syphilis upon the third generation are of a very mild character. Neither abortions nor still-births, nor dystrophic symptoms are as prevalent here as in the second generation. Acquired syphilis of the first generation is not transmitted to the third generation in any form known to us as characteristic of hereditary syphilis. But on the other hand neither is immuinty to syphilis bestowed upon the third generation. A father and mother suffering during conception or pregnancy with visible symptoms of late heredity do not transmit to the child syphilis in hereditary form. The writer did not observe in his case the transmission of syphilis from the grandfathers to grandchildren, the parents being free from manifestations of the disease, and in his opinion this possibility can hardly be admitted. Syphilitic heredity of the second generation has only a dystrophic effect upon the third generation, and this dystrophic effect of syphilis, which is mostly expressed in the vital generic-procreative energy of the diseased organism, is in no way parallel to the mildness or severity of the symptoms seen in the first or second generations. The dystrophic changes of the second generation are not transmitted as similar dystrophic changes to the third generation. Hereditary syphilis in the third generation is only seen when the second generation, born from syphilitic parents, acquires extra-uterine syphilis (syphilis binaria of the writer). Syphilis binaria is seen in cities, but more often in villages (the writer has here in mind Russian villages and the mode of life of their inhabitants. Ref.). Also in cases, when members of a second generation of syphilis marry people who have acquired syphilis, the third generation may have symptoms of hereditary syphilis.

Syphilis binaria runs a different course from syphilis acquired by healthy persons. The writer considers three forms of this disease: S. binaria abortiva, lues, and atypica. Syphilis binaria has a more detrimental effect upon the third generation, than syphilis of the first generation upon the second. This detrimental effect is expressed by a quite large increase of abortions, still-births and deaths in the first years of life, by the appearance in the third generation of symptoms of hereditary syphilis coupled with dystrophies and by a large diminution of normal progeny. Anatomical and functional dystrophies of the second and third generations of syphilities play an important rôle in the diminution of progeny in syphilitic families. Syphilis binaria is the main reason of the degeneration of a people, especially in endemic syphilis in villages and small places. The supposition that syphilis will lose its destroying character with syphilization of the people cannot be accepted at present. Syphilis is more dangerous for the life of a community than of an individual.

1. A Little Known Symptom Which Often Accompanies Carcinoma in Human Beings.— PROF. LESER (*Münch. Med. Woch.*, 48, 1902, 2035.)

2. Relation of Angiomata to Carcinoma.—GEBELE (*Münch. Med. Woch.*, 49, 1902, p. 139.)

In examining fifty cases of undoubted carcinomata of various organs Leser noticed in forty-nine cases the simultaneous presence of angiomata in various numbers upon the skin of the affected patients and considers himself entitled to conclude that angiomata are of common occurrence in carcinomatous patients. In order to decide the question whether angiomata are not seen in healthy, that is, in patients not suffering with carcinomata, three hundred such persons were examined with the result that in aged persons free from carcinoma, angiomata occur, although carcinomatous patients have angiomata at an earlier period. The occurrence of angiomata in young persons can be utilized as a diagnostic aid. These conclusions are questioned by Gebele, who examined 21 cases of undoubted carcinoma and two hundred of a number of other diseases. Only a little over half of the former presented angiomata and in the latter they occurred in 43 per cent. The writer regards the presence of angiomata as a sign of retrogressive change in the tissues, most marked in advanced age and of no value for purposes of diagnosis.

The So-called Profeta's Law.— L. GLUCK (*Wien. Med. Woch.*, 1902, p. 406.)

The writer questions the validity of Profeta's law, owing to the following case, which came under his observation. A mother 20 years old married one year came to the hospital with her eleven months' old baby. On her admission to the hospital the mother presented a macular eruption of the body, large condylomata of genital organs, breasts, anal region and mucous patches of the lips of the mouth, tongue and palate and a general polyadenitis. The first appearance of the present disease, hard sores on the nipples of the breasts, was noticed when she was in her fourth month of pregnancy with the present living child. The mother did not notice any skin eruption, but she positively affirms that sores on the genital organs were present before the birth of the child. The husband does not show any signs of syphilis.

On the day of admission the child did not present any signs of syphilis. The mother was not allowed to nurse the child further. Eight days after admission a hard papule appeared on the chin of the baby, which gradually developed into a hard chancre with hard submaxillary glands and in due time an early syphilitic eruption of the body and mucous papules of the mouth were seen by the writer. Thus a mother affected with recent syphilitic manifestations can infect her healthy baby—nursing in the first weeks of its life.

Herpes Zoster and Its Relation to Internal Inflammations and Diseases.— Especially the Serous Membranes.—ROLAND G. CURTIN (*American Journal of Medical Sci.*, 123, 1902, p. 264.)

The writer reports ten cases of Herpes Zoster combined with various diseases as pleuritis, peritonitis, Bright's disease, appendicitis, esophageal cancer and raises the questions: (1) Whether the internal disease is not a Zoster of the serous membrane? (2) Whether the inflammation of the internal filaments of the nerve was communicated to the pleura and peritoneum. (3) Whether the internal inflammation caused the Zoster. (4) Whether both troubles were independent or coincident?

Roentgen Rays as Means for Diagnosis of Syphilis of the Bones.—A. T. POSTELOW (*Russ. Jour. of Skin and Ven. Dis.*, Vol. III., 1902, 228.)

In many cases of late syphilis of the bones, especially where bones are affected which are covered with a thick muscular layer, as the thigh, where palpation is hardly sufficient to localize the disease, the rays are of great value in differentiating between muscular changes and affections of the bones. He cites five cases to the point, in some of which no correct diagnosis could be made without the use of the rays.

GENITO-URINARY DISEASES.

The Practical Application of the Combined Operations of Internal and External Urethrotomy.—By REGINALD HARRISON, F.R.C.S. (*Edinburgh Med. Journal*, January, 1902, p. 33.)

Harrison calls attention to this procedure, which he thinks, does not appear to be sufficiently known. It has much to recommend it, both theoretically and practically.

Instances of acute and extensive extravasation of urine are not infrequently met with. The remote effects following extravasation and sloughing of the parts should be borne in mind. Subsequent plastic operations, undertaken for the removal of adhesions following the sloughing process, may be avoided if this contingency has been foreseen.

However clumsy and violent the process may appear, suppuration in connection with a stricture, and subsequent extravasation of urine and tissue destruction, is nature's way, short of a sudden rupture without warning, of getting rid of so dangerous a compound as urine may prove when it is pent up by a stricture or obstacle even within the limits of its natural barriers. This process is really a conservative one, though this may be a difficult thing to recognize. The case of a traveller is mentioned, who was the subject of an old traumatic stricture. While in the bush, hundreds of miles away from medical attendance, he was seized with retention, and went through the process of an acute and extensive extravasation, and subsequently the formation of several urinary fistulæ, absolutely unattended. He is still alive, and in good health, his life having been undoubtedly saved by what may very properly be called a series of catastrophies.

It is generally agreed that in the treatment of these cases, at least two main objects should be kept in view—first, to secure a free and direct escape for the entire content of the bladder; secondly, to provide in a similar way for the urine that is extravasated and confined.

To attain these objects, the patient is anesthetized, and the internal urethrotomy is first performed. It is highly important that the second part of the operation be carried out on a grooved staff of ample dimensions. This end is best secured by the use of the Maisonneuve urethrotome, which is the preferable instrument for this purpose. The flexible guide is first passed, the director follows, and the knife being run along in its groove, makes the section of the stricture, thus completing the first part of the operation. It rarely happens that this cannot be accomplished the bladder pressure being taken off the extravasation that has occurred. A large median grooved staff is now passed into the bladder, and the external urethrotomy is performed, the incision being large enough to permit the introduction of a full-sized perineal drainage tube; the opening in the tube should be made as near as possible to the junction of the membranous with the prostatic urethra, as in Cocks' operation. The drainage tube

should precisely fit the perineal wound. This permits no side leakage of blood or urine, and no burrowing of the latter through the interspaces made by the extravasated urine.

For some years, Harrison has used, for the second stage of perineal control drainage (with the object of getting the patient up and about as soon as possible), the rubber tubes with a tap, which were first brought to notice by Professor Annandale. They should fit the wound in each case, and are substituted for the rigid gum elastic ones, when the latter are removed at the expiration of three or four days after the operation, and when the risk of bleeding is unlikely.

Having secured a free and direct escape for the urine from the bladder, the next step is to deal with the area of extravasation. In the scrotum the incisions should as far as possible, be confined to one or more, made on either side of the median raphé, according to circumstances. This secures a freer vent for the extravasated urine than an incision along the middle line would give. The incisions should be ample in length and depth, extending well into the cellular tissue. Much of the confined urine in this situation may be squeezed out through the wounds, the surgeon using his hands as if he were dealing with a wet sponge. In this way the scrotum can be reduced rapidly to almost normal dimensions, and much sloughing averted. Similarly, the abdominal parietes may be dealt with, wherever urine appears to have been extravasated.

Incisions should not be made in inconvenient places. Perineal tubes should be retained from ten to fourteen days, and the urethra treated subsequently, as after perineal section for stricture, by the passage of full-sized "whips" or ordinary bougies, daily or every other day, until healing has occurred, and then at gradually lengthening intervals. The length of these whips (24 inches), their pliability, and shape, enable them to dilate a stricture, however narrow by a single introduction, so that there is no chance of losing the way in a difficult case when once found.

Their more general use has largely diminished the number of so-called impassable or "incorrigible" strictures. Recently the writer has had some of them made with a groove (channelled whips), which serve the purpose of catheter as well as dilator, and may, on an emergency, act as a guide to the urethra, as in dealing with a perineal abscess or performing a perineal section. A flexible bougie will sometimes pass where a metal staff fails.

The subsequent management of these cases needs no special comment.

Where the internal urethrotomy cannot be performed because the stricture is found to be impassable to instruments, relief must be afforded by endeavoring to reach the bladder by a perineal incision, as in Cock's operation. This is by no means easy, as the bladder is now usually empty, and the perineum enormously swollen. Still the difficulty is not insuperable, and the surgeon is justified in undertaking it. This recourse is seldom necessary as the chances of introducing an instrument into the bladder are greatly in favor of the operator, when the patient is anesthetized, and the urethra freed from tension by reason of the extravasation that has occurred. The remainder of the process is at once simplified, when the introduction of a gum elastic catheter, which is a necessity, has been accomplished. For want of this, extravasation has continued to death, the urine only partially escaping through the scrotal and other side openings which may have been made surgically or by nature, and which had become blocked with pus and sloughs. Post-mortem examination often showed that the latter openings had no connection with the

urethra or bladder. In this way the high temperature, chills, and a dry tongue were explained.

The combined urethrotomies probably represent the safest and most efficient means of treating some forms of urethral stricture unfitted for dilatation, as measured by immediate and remote results. The chief objections to internal urethrotomy arise from the fact that, by reason of the construction of the wound, the liability to rigors and urinary fever is considerable. In a few instances the fever has been sufficient to cause death, marked by more or less suppression of urine. The writer does not recall having ever seen either death or urinary suppression following an external urethrotomy with drainage.

Furthermore he repeats the statement made to the International Congress of Medicine (Paris, 1900), "that there is direct evidence to show that the tendency to recontraction and recurrence of stricture, after internal urethrotomy, is largely diminished by concurrent employment of systematic and efficient urine and wound drainage, such as its combination with external urethrotomy or perineal puncture affords." A. L. W.

Chronic Urethritis and Its Treatment by Extract of Suprarenal Capsule. — By G. L. EATON, M.D. (*Occidental Medical Times*, March, 1902.)

Eaton states that the anterior urethra is twice as often the seat of chronic inflammation as the posterior, in spite of the commonly supposed idea that chronic urethritis is usually associated with some process involving the posterior urethra. The chronic condition existing in the urethra between acute attacks is aggravated by astringent injections. Chronic engorgement of the infected glands and follicles results, and is followed by erosion of the neighboring mucous membrane. The orifices of the ducts and follicles are dilated, frequently giving off muco-pus.

In this variety of urethritis the author has found the extract of the suprarenal gland of marked therapeutic value. It acts not as an astringent, but as a direct stimulant to the muscular coats of the blood-vessels. Absorption of embryonic tissue is thus brought about, and improvement of the general tone takes place.

Three cases are reported in which chronic urethritis was cured by the use of a solution containing the extract. In one case of posterior urethritis local applications through the endoscopic tube of a 10-per-cent. solution daily, are said to have practically cured the disease after 15 days of this treatment.

It should be added that in the so-called anterior cases, *i. e.*, those in which the solution was injected with a small hand syringe, there was a slight dilatation and inflammation of the right vesicle and ejaculatory duct. Massage of the vesicles was performed in addition to the injection into the anterior urethra, with good results.

The extract has been used in acute gonorrhea, but it is not to be recommended. The author does not give any reasons for this statement. A. L. W.

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